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SYMPOSIUM ON POST-CONFLICT HEALTH AND HEALTH SYSTEMS: ISSUES AND CHALLENGES

A Policy Report Submitted to the CCFPD by

The Canadian Public Health Association in collaboration with the London School of Hygiene and Tropical Medicine
19-21 March 2000
Ottawa

Department of Foreign Affairs and International Trade
Ministère des Affaires étrangères et du Commerce international
Canada

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Organized by the
Canadian Public Health Association
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IDRC
CANADA

Peacebuilding and Reconstruction Program Initiative, International Development Research Centre (IDRC)

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International Conference Secretariat, Canadian International Development Agency (CIDA)

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Peacebuilding and Human Security Division, Department of Foreign Affairs and International Trade

Canadian Centre for Foreign Policy Development, Department of Foreign Affairs and International Trade

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Acknowledgement

The main body of the symposium report was prepared by Suzanne Fustukian, Research Fellow, Health and Conflict, Health Policy Unit/London School of Hygiene and Tropical Medicine. The section on the discussion around research objectives and priorities was prepared by Dr. Anthony Zwi, Head, Health Policy Unit/London School of Hygiene and Tropical Medicine. Input to the preparation of the report was provided by Dr. Enrico Pavignani, Public Health Specialist/Mozambique, and James Chauvin, Assistant Director, International Programs/Canadian Public Health Association (CPHA).

The symposium was organized by James Chauvin and Randi Goddard, CPHA Conference Assistant.

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Preface

The interest of the Canadian Public Health Association (CPHA) in the rehabilitation, renewal and strengthening of health systems in post-conflict countries stems from its experience in supporting and implementing, with a variety of partner health organizations, activities in several post-conflict countries over the past decade. These include immunization programs in Pakistan for Afghani refugees following upon that country's civil war, reinforcing primary health care services in south-east Turkey to respond to the needs of Kurdish refugees as a result of the Gulf War, nurturing the active participation of civil society in the formulation and application of evidence-based health policy and programs in Palestine, and more recently, the rebuilding and renewal of the health care system in Kosovo. Between 1994 and 1998 CPHA was also engaged by the Canadian Department of Foreign Affairs to act as a technical advisor to the Office of the Special Coordinator Middle East Peace Process on issues relating to public health and Palestinian refugees.

CPHA also participated in two important seminars on health policy and program development in post-conflict countries, organized in April 1998 and in February 1999 by the Health Policy Unit of the London School of Hygiene and Tropical Medicine. Believing that the discussion from these two workshops should be brought to the attention of Canadian NGOs, academic institutions, CIDA and IDRC, to heighten awareness around the issues as a means to improve the effectiveness of health-promoting activities implemented in post-conflict situations and on the importance of assessing the impact of health sector activities on peacebuilding and reconstruction, CPHA held in Ottawa, in March 2000, in collaboration with LSHTM, the *Symposium on Post-conflict health and health systems: Issues and challenges.*

The Symposium brought together representatives from Canadian, US and British NGOs, academic institutions and donor agencies, as well as representatives from several post-conflict countries. The discussions served to highlight key issues that impact on the capacity of countries emerging from conflict to rebuild their often shattered health care systems. Better coordination among agencies and organizations involved in post-conflict activities, greater participation of local health professionals and community representatives, improved awareness of the potential consequences of health policies and programs on conflict resolution, the implementation of practical, tested and evidence-based approaches are some of the mechanisms that can be put into place to achieve the result of sustainable and effective renewal and rebuilding of health systems in post-conflict countries. Although health sector activities are implemented with the best of intentions, too often their impact on nurturing sustainable systems that respond to local needs and capabilities, and on resolving or exacerbating conflict, is overlooked.

National public health associations can play an important role in the rebuilding and the renewal of public health policy and services following a conflict situation. They can provide an independent, politically neutral and credible forum for debate and discussion. National public health associations can furnish needed human resources and links to expertise and technical resources from other countries. Their membership, often representing a broad cross-section of society, can contribute to the richness and diversity of the discussions. They can also act as sounding boards on issues deemed to be sensitive or controversial.

As the United Nations International Year for a Culture of Peace draws to a close, it is the hope of CPHA's International Programs that this Symposium report will result in a more sensitive approach to the planning and implementation of effective health-related activities in post-conflict countries. It is also hoped that national public health associations will become active participants in this process.

Préface

L'intérêt que porte l'Association canadienne de santé publique (ACSP) à l'égard de la remise en état, du renouvellement et du renforcement des systèmes de santé dans les pays se relevant d'un conflit émane de son expérience acquise au cours de la dernière décennie sur le plan du soutien et de la mise en oeuvre de diverses activités dans plusieurs pays qui se relèvent d'un conflit, ce qu'elle a fait en collaboration avec des organisations de santé partenaires. Ces activités comprennent, entre autres, la mise en place de programmes d'immunisation au Pakistan à l'intention des réfugiés de l'Afghanistan suite à la guerre civile qui a sévi dans leur pays, le renforcement des services de santé primaires dans le sud-est de la Turquie afin de répondre aux besoins des réfugiés kurdes victimes de la guerre du Golf, le soutien à l'égard de la participation active de la société civile dans la formulation et l'élaboration en Palestine de programmes et de politiques en matière de santé reposant sur des preuves scientifiques, et, plus récemment, le relèvement et le renouvellement du système de soins de santé au Kosovo. Également, le ministère canadien des Affaires étrangères a confié à l'ACSP le mandat d'agir à titre de ressource technique au Bureau du coordonnateur spécial pour le processus de paix au Moyen-Orient quant aux questions qui touchent la santé publique et les réfugiés palestiniens.

L'ACSP a également participé à deux séminaires clés qui ont porté sur l'élaboration de programmes et de politiques en matière de santé dans les pays sortant d'un conflit. Ces séminaires ont été mis sur pied par le Health Policy Unit de la London School of Hygiene and Tropical Medicine et ont eu lieu en avril 1998 et en février 1999. L'ACSP estimait qu'il était important que les détails sur la discussion et le débat qui ont découlé de ces ateliers soient portés à l'attention des ONG et des établissements d'enseignement supérieur canadiens ainsi que de l'ACDI et du CRDI, afin de sensibiliser davantage les gens à l'égard de ces questions. Elle a également soutenu que cette démarche contribuerait à améliorer l'efficacité des activités de promotion de la santé mises en oeuvre dans les situations postérieures à un conflit, et elle a souligné l'importance d'évaluer les répercussions des activités du secteur de la santé sur la consolidation de la paix et la reconstruction. Pour cette raison, en mars 2000, l'ACSP, en collaboration avec la London School of Hygiene and Tropical Medicine, a tenu à Ottawa le colloque sur les enjeux et les défis des systèmes de santé des pays se relevant d'un conflit.

Le colloque a rassemblé des représentants d'ONG, d'établissements d'enseignement supérieur et d'organismes fondateurs du Canada, des États-Unis et de la Grande-Bretagne, de même que des représentants de plusieurs pays se relevant d'un conflit. Le but des débats qui y ont eu lieu était de mettre en évidence plusieurs questions clés qui ont une influence sur la capacité des pays émergeant d'un conflit de reconstituer leurs systèmes de santé. Dans bien des cas, ces derniers ont été démantelés. L'amélioration de la coordination parmi les organismes et organisations qui contribuent à la mise en place d'activités pour les pays émergeant d'un conflit, l'augmentation de la participation des professionnels de la santé locaux et des représentants de la collectivité, l'augmentation de la sensibilisation à l'égard des conséquences possibles des programmes et politiques en matière de santé sur la résolution de conflits, ainsi que la mise en œuvre d'approches pratiques, mises à l'essai et reposant sur des preuves scientifiques constituent quelques-uns des mécanismes qui peuvent être mis en place pour qu'il y ait un renouvellement et un relèvement durables et efficaces des systèmes de santé dans les pays sortant d'un conflit. Trop souvent, même si on met en œuvre des activités dans le secteur de la santé avec les meilleures intentions, on ne tient pas compte de leurs répercussions sur les systèmes durables offrant du soutien qui répondent aux besoins locaux et correspondent aux capacités locales, et sur celles se rattachent à la résolution ou à l'exacerbation des conflits.

Les associations nationales de santé publique peuvent jouer un rôle important dans le relèvement et le renouvellement des services et politiques en matière de santé publique à la suite d'un conflit. Elles peuvent offrir un forum indépendant, crédible et neutre sur le plan politique en vue d'un débat ou d'une discussion. Les associations nationales de santé publique peuvent fournir les ressources humaines requises et les liens à des spécialistes et des ressources techniques d'autres pays. L'effectif de ces associations, qui représente souvent un vaste échantillon de la société, peut contribuer à la richesse et à la diversité des débats. Les associations peuvent également tester les diverses réactions dans le cas des questions considérées comme étant de nature délicate ou prêtant à controverse.

Comme la fin de l'Année internationale de la culture de la paix des Nations Unies approche, les responsables des programmes internationaux de l'ACSP espèrent que le présent rapport du colloque mènera à une démarche plus objective à l'égard de la planification et de la mise en oeuvre d'activités efficaces liées à la santé dans les pays émergeant d'un conflit. On souhaite également que les associations nationales de santé publique en viennent à participer activement au processus.

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Executive Summary

On March 19 – 21, 2000, a symposium was held in Ottawa, Canada, on the issues and challenges of health and health sector renewal and rehabilitation in countries emerging from conflict. Organized by the Canadian Public Health Association (CPHA), in collaboration with the Health Policy Unit of the London School of Hygiene and Tropical Medicine (LSHTM), the event brought together over forty participants representing Canadian, British, and American NGOs and research institutions and their partners from four African countries and two countries in the Balkans, donor agencies, and the World Health Organization. The symposium was the third in a series of meetings focusing on health and the challenges of working in a post-conflict environment.

The objectives of the symposium were:

- to analyse the challenges to health and health systems facing countries emerging from conflict;
- to offer suggestions regarding health policy and planning needs in these countries;
- to critically reflect upon the positive and negative aspects of the international response to their health systems; and
- to define a research framework for impact assessment on health and health systems interventions and on health policy and planning decision-making in countries emerging from conflict (see research report at end of the report, plus subsequently developed proposal).

The Ottawa symposium sought to broaden the discussions with input from several individuals and organizations working in post-conflict countries that had not participated in two previous workshops, and to expand the participation of Canadian and American-based organizations and donor agencies. Its aim was to refine and take forward a research agenda of the priority areas identified, to introduce and promote the concept and a methodology for measuring the impact of health-related interventions on peacebuilding and conflict resolution, and to facilitate the development of effective partnerships between in-country personnel, research groups, NGOs and donor agencies.

The symposium generated lively discussion and debate around the issues at hand. Case studies were presented from Mozambique, Angola, Rwanda, Sierra Leone, Somaliland, Kosovo, Bosnia and Herzegovina, and East Timor. The key points of discussion included the impact of unpredicability on the capacity to effectively plan and implement policies and programs in a post-conflict situation, issues related to who controls the agenda and power in such situations, the politics of health-related interventions, the need to demystify language and approaches, to make them useful to field workers, and the focus of health interventions (the relationship between trying to influence the impact of the "determinants" of health and reconstruction/renewal of conventional health services and systems).

The participants urged the linking up of practitioners and academics to undertake applied research around peacebuilding and other issues that had come up during the symposium. Key research issues highlighted were:

- to what extent has an effective overarching policy framework been established for guiding health system development?

- In what ways have the roles of key actors changed over the period of transition?
- To what extent has equity been placed on the agenda?
- To what extent peacebuilding is identified as an explicit objective? and,
- What is the role of information in influencing policy decisions?

Understanding how questions are phrased and framed, and how solutions are to be sought will be important to examine within the research undertaken, but is also relevant to the research process to be undertaken. Ensuring a high degree of local ownership and participation will greatly enhance the value of the project and ensure that beyond key questions which may form the core of the comparative elements of the project, there is considerable scope for additional dimensions to be developed to reflect specific concerns.

The participants also proposed several future activities to maintain the momentum of the symposium. It is important to identify and disseminate information as to what other initiatives exist in this field and to ensure complementarity between them. The meeting discussed the establishment of a web-site and virtual network of researchers and others interested in maintaining links around post-conflict health policy development. This web-site could house ongoing analyses and assessments from different countries plus make available tools, guidelines and policy documents for perusal. It was also suggested that follow-up regional meetings take place, to inform a wider audience about the discussions and to encourage wider participation in the proposed network. One such venue might be a follow-up seminar for Canadian NGOs and academic researchers at the forthcoming Canadian Conference on International Health (Ottawa: November 2000).

There is a need to ensure that lessons are fed into future post-conflict situations. The initiative by the LSHTM and CPHA remains very committed to facilitating such research, documentation, analysis and dissemination of best practice.

Sommaire executif

Lors d'un colloque qui a eu lieu du 19 au 21 mars 2000 à Ottawa (Canada), on s'est penché sur les enjeux et les défis relatifs à la santé ainsi que sur le renouvellement et la remise en état du système de santé dans les pays sortant d'un conflit. Le colloque, qui a été organisé par l'Association canadienne de santé publique (ACSP) en collaboration avec la Health Policy Unit de la London School of Hygiene and Tropical Medicine, a réuni plus de quarante participants. Certains représentaient des ONG et des établissements de recherche du Canada, de la Grande-Bretagne et des États-Unis. Leurs partenaires de quatre pays africains et de deux pays des Balkans étaient également présents, tout comme des représentants d'organismes donateurs et de l'Organisation mondiale de la Santé. Le colloque était la troisième d'une série de réunions sur la santé et sur les défis que représente le travail dans un milieu qui se relève d'un conflit.

Les objectifs du colloque étaient les suivants :

- analyser les défis relatifs à la santé et aux systèmes de santé auquels sont confrontés les pays se relevant d'un conflit;
- faire des recommandations relativement aux besoins qui touchent la planification et les politiques en matière de santé dans ces pays;
- poser un regard critique sur les aspects positifs et négatifs des mesures d'intervention internationales à l'égard des systèmes de santé de ces pays; et
- définir un cadre de recherche en vue de l'évaluation des répercussions sur les mesures d'intervention à l'égard de la santé et des systèmes de santé, et sur la prise de décisions touchant la planification et les politiques en matière de santé dans les pays sortant d'un conflit (consulter le rapport de recherche à la fin du rapport ainsi que la proposition qui a été élaborée par la suite).

Le but du colloque d'Ottawa était d'élargir la portée du débat en recueillant les commentaires des individus et organismes qui travaillent dans les pays se relevant d'un conflit et qui n'avaient pu participer aux deux ateliers précédents, et d'augmenter la participation des organisations et organismes donateurs canadiens et américains. Le colloque visait à mettre au point et à présenter un programme de recherche en rapport avec les secteurs prioritaires établis, à mettre en place et à promouvoir un concept et une méthodologie en vue d'évaluer les répercussions des mesures d'intervention en matière de santé sur la consolidation de la paix et la résolution de conflits, et à favoriser l'établissement de partenariats efficaces entre le personnel sur le terrain, les groupes de recherche, les ONG et les organismes donateurs.

Le colloque a engendré un vif débat et de vives discussion sur les questions de l'heure. On y a présenté des études de cas du Mozambique, de l'Angola, du Rwanda, de la Sierra Leone, du Somaliland, du Kosovo, de la Bosnie et de l'Herzégovine, ainsi que du Timor de l'est. Les principales questions à débattre comprenaient l'influence de l'imprévisibilité sur la capacité de procéder efficacement à la planification et à la mise en œuvre de politiques et de programmes dans les situations postérieures à un conflit, les précisions quant à savoir exactement qui contrôle le programme et le pouvoir dans de telles situations, les politiques des mesures d'intervention en matière de santé, la nécessité de démystifier le langage et les approches afin d'en assurer l'utilité pour les travailleurs sur le terrain, et le rôle important que jouent les mesures d'intervention en matière de santé (lien entre les efforts axés sur l'influence des répercussions des « facteurs déterminants » de la santé et le relèvement et le renouvellement des systèmes et des services de santé traditionnels).

Les participants ont insisté sur l'importance de la collaboration entre les intervenants et les universitaires afin d'entreprendre une recherche appliquée relativement à la consolidation de la paix et à d'autres questions qui ont surgi au cours du colloque. Les thèmes de recherche clés mis en évidence sont les suivants :

- Dans quelle mesure a-t-on établi un cadre de politique englobant et efficace en vue de l'orientation du processus d'élaboration de systèmes de santé?
- De quelle façon le rôle des intervenants clés a-t-il été modifié au cours de la période de transition?
- Dans quelle mesure la question de l'équité a-t-elle été inscrite au programme?
- Dans quelle mesure la consolidation de la paix est-elle considérée comme un objectif explicite?
- Quel est le rôle de l'information dans l'influence des décisions relatives aux politiques?

Dans le cadre des activités de recherche, il sera important de savoir comment les questions sont structurées et encadrées et comment des solutions devront être trouvées, mais cette compréhension s'applique également au processus de recherche qui sera entrepris. Le fait de s'assurer d'un taux élevé de participation et de prise en charge à l'échelle locale contribuera grandement à augmenter la valeur du projet, ce qui signifiera qu'au-delà des principales questions qui pourraient former le noyau des éléments comparatifs du projet, on laissera dans une grande mesure la porte ouverte à l'élaboration d'autres dimensions qui correspondront à des préoccupations particulières.

Les participants ont également proposé plusieurs activités éventuelles afin de maintenir l'élan du colloque. Il est important d'établir et de diffuser des renseignements quant à savoir quelles autres initiatives existent dans le secteur, et de s'assurer de la complémentarité entre ces renseignements. Au cours de la réunion, on a discuté de la question de l'établissement d'un site Web et d'un réseau virtuel de chercheurs et d'autres personnes intéressés a maintenir des liens quant à l'élaboration de politiques en matière de santé dans les pays se relevant d'un conflit. Le site Web en question pourrait loger de l'information sur les évaluations et analyses en cours dans différents pays en plus de permettre l'utilisation d'outils, de lignes directrices et de documents de politiques en vue de leur consultation. On a également suggéré la tenue de réunions de suivi à l'échelle régionale dans le but de fournir des renseignements sur le débat à un plus large auditoire et de favoriser une plus grande participation dans le réseau proposé. On pourrait, entre autres, tenir un séminaire de suivi à l'intention des ONG et chercheurs universitaires canadiens à la prochaine Conférence canadienne sur la santé internationale (qui aura lieu à Ottawa en novembre 2000).

Il faut pouvoir s'assurer que les leçons que l'on a tirées serviront dans d'éventuelles situations postérieures à un conflit. L'initiative mise en place par la London School of Hygiene and Tropical Medicine et l'ACSP demeure bien résolue à favoriser ce genre de recherche, de documentation, d'analyse et de diffusion de renseignements à l'égard des meilleures pratiques.

Introduction

A Symposium on Post-Conflict Health and Health Systems: Issues and Challenges was held March 19-21, 2000 in Ottawa, Canada, hosted by the Canadian Public Health Association (CPHA) in collaboration with the Health Policy Unit of the London School of Hygiene and Tropical Medicine. The CPHA is working in a number of post-conflict settings and has devoted particular attention to supporting the emergence of public health associations and the renewal and rehabilitation of the public health infrastructure. The LSHTM, in responding to the health and health system challenges in countries emerging from conflict, is committed to ongoing research, documentation and national capacity building in this field.

The Symposium was attended by forty participants (see Appendix 1), representing Canadian, British and American NGOs and research institutions and their partners from four African countries and two countries in the Balkans, as well as donor institutions and the World Health Organization. The Symposium was supported by the Peacebuilding and Reconstruction Program Initiative/International Development Research Centre (IDRC), the International Conference Secretariat at Canadian International Development Agency (CIDA), the Canadian Department of Foreign Affairs' Peacebuilding and Human Security Division and the Canadian Centre for Foreign Policy Development.

The Symposium was the third in a series of meetings focusing on health and the challenges and complexities of working in a post-conflict environment (see Appendix 2). Five of the participants in the Ottawa meeting had taken part in the previous two meetings allowing continuity of discussion from these meetings while building on their conclusions/recommendations with additional experience from Canada and a different group of 'post'-conflict countries.

The objectives for the Symposium were:

- to analyse the challenges to health and health systems facing countries emerging from conflict;
- to offer suggestions regarding health policy and planning needs in these countries;
- to critically reflect upon the positive and negative aspects of the international response to their health systems; and
- to define a research framework for impact assessment on health and health systems interventions and on health policy and planning decision-making in countries emerging from conflict (see research report at end of the report, plus subsequently developed proposal).

Brief presentations (see agenda in Appendix 3) were given on the health situation in eight 'post'-conflict countries: Mozambique, Angola, Rwanda, Sierra Leone, Somaliland, Bosnia, Kosovo, and East Timor. Selected issues from their experience of rebuilding the health sector were identified and discussed, with further comment on their specific and collective experience contributed by donor agency representatives and academics. The participants were also introduced to two 'peacebuilding' initiatives: the Peace and Conflict Impact Assessment (PCIA) instrument, developed under IDRC auspices and presented by Dr. Ken Bush, and WHO's Peace through Health initiative in the Balkans, presented by Gregory Hess.
The Ottawa Symposium also sought to refine and take forward a research agenda of the priority areas identified at the Ottawa Symposium and from the previous two meetings, in

consultation with NGOs, research institutions and post-conflict country representatives. The aim was to facilitate the development of effective partnerships between country personnel, research groups, NGOs and donor agencies.

The transition from conflict to peace

The transition from conflict to peace, particularly in the immediate 'post'-conflict period, is fraught with uncertainty, lack of clarity, and continuing chaos as individuals, interest groups and politicians jockey for position, and sometimes survival, in new political environments. There are losers and winners in this new situation, and as ever, the vulnerable and powerless may regain little security. This is particularly so in situations where a return to conflict is an ever-present threat, destroying the fragile peace that has been achieved. Angola and Sierra Leone have experienced such returns to violence, following hard-won peace agreements in 1994 (Angola) and 1999 (Sierra Leone), while East Timor, Bosnia, Kosovo and Somaliland are proceeding with the process of reconstruction. Mozambique has had uninterrupted peace and relative security since the peace agreement was signed in 1992; their experience, and that of Uganda, Cambodia, Palestine and other 'post'-conflict countries not represented at the Symposium, continue to inform the development of insights and policy proposals.

The transition is 'signalled' by a combination of actions. These include an (at least temporary) cessation of fighting, a cease-fire or the commencement of talks to stop the fighting; a change in national and international community perspectives suggesting that the conflict is receding or over; and changing political leadership and systems of governance, usually associated with the outcome of the war, elections, or a coup (Macrae et al, 1995). Although there may be an improvement in stability and security, violence may continue in many areas, and absolute peace may be difficult to re-establish. Governance structures essential to both decision-making and implementation are commonly absent or weak in 'post'-conflict countries; in many cases, state failure or state collapse were among the key reasons for the progression to violent conflict (Cliffe and Luckham, 1999). This was frequently made visible through the inequitable distribution of development resources, services, and economic and political power.

Rebuilding, or creating anew as in East Timor and Kosovo, the governance capacity of these countries, including health governance, is central to their recovery, particularly their capacity to deliver "*the fundamental matters of providing security against violence, stable money for trade and investment, a clear system of law and the means to enforce it and a sufficiency of public goods like drains, water supplies, infrastructures for transport and communications*" (Strange, 1996 in Collinson, 1999). Governance is a multi-dimensional concept that goes beyond the mechanistic systems of rules, processes and institutions of government and reflects the less tangible relationships between different levels of government administration and between government and different groups within civil society. At the core of rebuilding, governance represents a much more fundamental and long-term process of recovery. The process through which states and their populations 'reinvent' themselves after devastating conflict also raises profound questions and issues about forgiveness, resilience, trust, and solidarity. Understanding the deep healing needs of such countries – at all levels and dimensions - is infrequently found among the international community, particularly in their expectation of a swift return to 'normality'.

Summerfield (1995), for example, argues for a commitment that *"the major thrust of interventions [...] be towards the social world of survivor populations, for herein lie the sources of resilience and the capacity for recovery for all...the core task is to address the social and collective wounds of war."* The aim he suggests is to support *"projects [that] can help people sustain their weakened social 'space', or carve some out afresh, which in a partial way can perform some of the functions which peacetime society used to do: to generate a social meaning for events, to recognise, contain and manage grief and its social face, mourning; to stimulate and organise active coping and problem solving, individual and collective, in the face of continuing adversity."* **Ken Bush**, one of the Symposium's presenters, has also highlighted the importance of 'space' in strengthening local processes: *"the most obvious, and the most overlooked, characteristic of post-war peace and reconstruction is that it is not about the imposition of 'solutions,' it is about the creation of opportunities. The challenge is to encourage the creation of the political, economic, and social space, within which indigenous actors can identify, develop, and employ the resources necessary to build a peaceful, prosperous and just society"* (Bush, 1995).

These two inter-twined positions reflect some of the main themes that the Symposium participants debated: the range of roles played by indigenous civil society actors, national and local government officials, as well as external actors in post-conflict health sector reconstruction. More often, the participants considered that solutions were imposed by external agencies without sufficiently involving local actors, such as health professionals or civil society. Other key issues identified included:

- the role of transitional authorities (e.g. UNMIK in Kosova, UNTAET in East Timor) and ownership re: policy making and priority setting;
- the coherence and coordination of external aid in reconstruction, in particular the World Bank (e.g. Bosnia-Herzegovina, East Timor) and NGOs (e.g. Kosovo; Somaliland);
- the role of WHO in policy coordination (e.g. Bosnia-Herzegovina, Kosovo);
- concerns with health financing, in particular cost recovery and insurance mechanisms (all countries);
- the potential of linking health actions with peacebuilding– 'peace through health' / peace and conflict impact assessment (e.g. Kosovo, Bosnia-Herzegovina);
- (re)building health systems (institutions, relationships) within a wider framework – linkages across sectors/ HRD/ capacity building (e.g. Angola, Kosovo, Rwanda);
- transformation of parallel/informal systems to formal system (Kosovo/ Somaliland) and consequences for local NGOs
- ensuring cross-sectoral links that enhance human security, especially for vulnerable groups;
- the impact on health systems reconstruction with a return to conflict (e.g. Angola, Sierra Leone).

Peacebuilding and human security

Many of these issues were also approached through a discourse on peacebuilding and the role and contribution of the health sector to this process, covered in more detail below. The participants agreed that an emphasis on 'human security' (UNDP, 1994) is needed in which the interdependence of livelihood, peace and security and essential social support is acknowledged and acted on. The emphasis of 'post'-conflict policy on an integrated approach to these three vital areas would then focus on supporting and strengthening local initiatives -

both local government structures and emerging civil society organisations. Sectoral collaboration is equally critical: health and other social services are vital in supporting people and rebuilding local capacity during this period of transition. Above all, promoting the development of a more equitable health and social system may provide an important opportunity for bringing together different groups within affected populations, and lead to early opportunities to stimulate debate, exchange of ideas, and the rekindling of trust.

Rebuilding an integrated health system

The challenges of (re)building an integrated health system are broadly experienced by many countries, whether conflict-affected or not. However, the challenges facing countries emerging from conflict are multiplied substantially by their recent conflict experience. In most situations of 'post'-conflict, the system inherited is severely fragmented, with vertical control programmes frequently delivered by parallel services established by external relief agencies (WHO, 1998: 10). Unsustainable operational standards and facilities are commonly put in place. Institutional, technical, and management capacity is frequently poor in post-conflict countries with limited or no health information available for adequate needs assessment or service planning. Humanitarian agencies often fail to adequately support indigenous capacity during either the emergency or rehabilitation periods thus increasing the risk of little being left behind when they withdraw.

Despite a cessation of formal hostilities, "*health does not improve readily in the aftermath of violent conflict*" (WHO, 1998: 10). Refugees and internally displaced people typically experience high mortality in the emergency phase following their migration; in children, deaths result from malnutrition, diarrhoea and infectious diseases, while in adults, STDs and HIV may be exacerbated, as may other communicable diseases, such as malaria, tuberculosis and a variety of water-related conditions. Psychological distress may be widespread, demanding efforts to re-establish communities and their livelihoods. Injuries, violence, and specifically violence against women may be widespread and require attention despite often being stigmatised. Work with sectors other than health is clearly important.

The matrix developed by the LSHTM (Appendix 4), based on the themes emerging from the previous two workshops and circulated prior to the March 2000 meeting, is used in this document to reflect on the key issues and debates that emerged from the Ottawa Symposium

Mozambique case study

To run health services following the peace agreement was far more difficult than had been anticipated. In 1993, after the peace agreement had been implemented, the system was unable to adapt quickly to the new transition environment, and service output contracted, as operations slowed down. Rebuilding in devastated rural areas was slow and expensive. Roads were often unpassable, due to land mines...and disrepair. Health workers were reluctant to move out of the main towns. The few and only partially operational vehicles had to cover long distances to work in the newly opened areas. This resulted in a dramatic contraction of the NHS fleet within few months after the peace agreement. Hence, as displaced populations returned home, their access to the existing health facilities decreased (Pavignani, 1999)

1. Public health concerns and health system development needs

The presentations commonly documented widespread destruction of health infrastructure, significant loss of health personnel, and almost universal absence of planning and management structures, including health information systems. Population health in the non-European countries was considered precarious, routinely affected by endemic malaria, acute respiratory infections, diarrhoeal diseases, measles, malnutrition, and other severe diseases. Infant and child mortality rates were typically extremely high and quoted as being 125/1000 and 139/1000 in Rwanda; 146/1000 and 260/1000 (1990) in Sierra Leone; and 175/1000 and 250/1000 in Somaliland. Tuberculosis and HIV/AIDS are considerable problems in Rwanda and Sierra Leone; TB is also a major problem in Somaliland and Kosovo while the extent of HIV/AIDS is unknown. Reproductive health was also of major concern: in Somaliland, the maternal mortality rate was estimated at 1600/100,000; in Sierra Leone 700/100,000 (1990); and 810/100,000 in Rwanda. In Somaliland, reproductive health was "further compromised by the pervasive practice of FGM (female genital mutilation)." Many of these statistics, however, are highly unreliable given the breakdown in the health service infrastructure mentioned earlier. The importance of reliable data and baseline information of health needs to the development of health policy cannot be over emphasised; in transitional situations, innovative means of making available up-to-date information need to be developed. In almost all cases, immunisation programmes have been given a high priority, although some critics have argued that establishing separate and parallel EPI programmes may undermine the development of an integrated health system.

Several presenters noted that urban areas have been affected in a variety of ways, typically with large population movements from unsafe to more secure settings. For example, in Sierra Leone, **Theresa Benjamin** reported that people moved to the urban settlements of Freetown, Bo and Kenema, perceived as more secure. In many cases, however, the capacity of local governments and municipalities may be overwhelmed in their ability to deliver services.

Health services and their rehabilitation were noted as having a positive effect on morale; a new coat of paint on a peripheral clinic suggests a return to normality, even if this is far from the case. Attention to quality, however, is often poor, and longer term sustainability may be sacrificed in the quest for short term political gain, resulting from highly visible changes. In Rwanda, the reported hospital utilisation rate was 20%, a strong indication that the population has little confidence in the quality of the health services. Despite being severely under-resourced, **Jerome Kayitare** indicated that the government aims to ensure equitable coverage based on needs, and has developed a set of objectives for each health region, which will be costed and fit into overall health plan.

Landmines presented another common public health hazard in most of these countries. In Kosovo, there were an estimated 40,000 landmines at the end of the conflict; with the arrival of the KFOR peacekeeping force, ordnance disposal teams cleared all the major routes and population centres. UNICEF, as lead agency in mine-awareness activities, distributed posters and leaflets about the dangers of landmines and other unexploded ordnance (UNMIK, 2000). **Alma Kadic** identified the "1 million unexploded landmines and other ordnance" as one of

Bosnia-Herzegovina's main challenges. Estimates of 1 million mines of various types are also given for Somaliland (SCPD, 1999)- in this resource-poor environment, it is estimated that "clearance of Somaliland's landmines is likely to take decades" (SCDP, 1999).

2. Establishing a policy framework

In the aftermath of periods of conflict, the most critical first step is the development of consensus - both locally and internationally - about broad health system direction and the policy framework within which service provision will be undertaken (Zwi et.al. forthcoming). Key issues to be debated include the financing of health services, the extent to which they are decentralised, priority public health needs, human resource capacity and development, and the role of the private sector. These need to be seen within the broader context of promoting and consolidating the peace, re-establishing the economy, and facilitating the demobilisation of troops and their absorption into the economy, and facilitating the return of refugees and internally displaced people. Other key priorities include demining and establishing accountable systems of governance.

In 'post'-conflict countries, the absence of a legitimate or recognised authority often results in a vacuum in governance in general, and health governance specifically. Following the conflicts in Kosovo and East Timor, UN Transitional Administrations were established in June and October 1999, respectively, with full legislative and executive authority. Included among their mandates were responsibilities for health and social services, including policy development, coordination, capacity building, and fund-raising to meet rehabilitation targets. In both recent situations, the development of a policy framework was paramount, given the "new political and financial realities" faced by each entity. Governance arrangements following conflict differed in the other countries represented at the Symposium, with differing international involvement in these arrangements. Somaliland, for example, also declared its secession from the Federal Republic of Somalia (in 1991) but unlike East Timor, their secession has not been internationally recognised and support for reconstruction efforts has been insubstantial .
In East Timor, the World Bank organised and coordinated a Joint Assessment Mission in November 1999, which aimed to "*identify priority short-term reconstruction initiatives and provide estimates of external financing needs, covering health, education and other sectors*" . The speed with which the Mission was deployed following the return to peace represented a lesson learned from other 'post'-conflict situations: that the "*lack of coordination between relief and development planning ... delayed the transition from emergency relief to more sustainable development support, and ... caused inefficiencies and duplication in the use of external resources*" (ibid). Among the priorities identified by the Mission's Health and Education team, according to **Egbert Sondorp**, a member of the Mission, was the development of a new health policy: the team recommended the early installation of a 'central health authority' within UNTAET to fulfil this function. Other recommendations included: employ all existing staff on a temporary basis; provide a training/capacity building programme to upgrade existing staff and train new higher cadres; provide free basic health services for the next two years; ensure a commitment from the international community to fill the 'manpower' gap; design a health financing strategy, including a public/private mix; and establish a coordination entity.

In Kosovo, a Health Policy and Planning Working Group, consisting of WHO staff members and senior health professionals from Kosovo, produced a document presenting 'interim health policy guidelines and [a] six-month action plan' in September 1999 (UNMIK, 1999). The underlying principles of the reformed health care system are equity, acceptability, effectiveness, flexibility, sustainability, non-discrimination and appropriateness. Five out of 21 targets from WHO's European Region were selected to act as the "focus of health sector attention and activity" during the period of the UNMIK administration:

1. Healthy start in life – to reduce neonatal and infant mortality and morbidity;
2. Improved health of young people – to protect young Kosovars from the negative effects of tobacco, alcohol, drugs, unwanted pregnancies and sexually transmitted diseases;
3. Improving mental health – to reduce the burden of mental health problems, injuries and violence;
4. Managing for quality of care – to improve the quality of health care at primary and secondary level through regular attention to health outcomes;
5. Developing human resources for health.

Emphasis was given to developing a system of primary care, acting as a gatekeeper to secondary and tertiary levels, and organised along a "family medicine concept emphasising teamwork" (UNMIK, 1999). Public provision predominates, although private practice is to be allowed. The document further elaborates nine action areas with specific objectives and strategies for each: primary care; maternity care; mental health; services for those with learning disabilities; emergency transport services; secondary care; drugs and medical supplies; prevention and rehabilitation of physical disability; and public and environmental health. **Ismet Lecaj** and **Jeannie Chamberlain**, while jointly raising the question as to whether it was realistic to develop a policy so early in 'post'-conflict Kosovo, agreed that the interim policy had had the potential to 'ground the programme' and 'redirect talent'. The policy, they affirmed, provided a strong theoretical framework for establishing primary care, reversing the previous neglect of these services under the Federal Republic of Yugoslavia, but that its effective implementation required both sound coordination with and an established health information system. These two issues will be returned to in the following sections..

In the presentation by **Enrico Pavignani,** it was evident that the Ministry of Health in Mozambique had had the foresight and capacity to develop a policy framework guiding 'post'-conflict reconstruction of the health sector even prior to the peace agreement signed in 1992. This framework proved to be influential in early discussions with donor agencies, indicating a capacity for planning and policy development. However, this was made possible because, unlike other countries that have experienced the loss of senior professionals as a result of chronic conflict, Mozambique retained many of its senior health planners throughout the conflict. Hence, experience and knowledge of the country and the health sector led to the development of plans that were built on a "limited but solid information base" that permitted "sensible policy discussion ... allowing for better decision making" (Pavignani, p.5). Health policy, as promoted by the Mozambican Ministry of Health, were considered to be sensible and convincing by many international agencies, who did their best to implement them. Principles of "equity, affordability and sustainability" were emphasised while the more politically charged issues such as health financing, particularly user fees were avoided

(Pavignani, p.9). Unfortunately, avoiding policy reform of the financing system during the 'post'-conflict period has now led to a "widespread, chaotic system of illegal, but widely tolerated, charges" (Pavignani, p.16).

In Angola, the absence of any policy direction from the central Ministry of Health in Luanda left provincial health authorities to manage as best as they can with limited resources and pressing priorities. **Enrico Pavignani** described an innovative NGO project in Benguela and Huambo provinces that began in 1994 as part of a multi-agency 'health transition project' involving institutional capacity building, including an emphasis on policy formulation at the central level. The larger project, initiated as part of the 'post'-conflict effort to rebuild health and social systems/infrastructure in Angola following the Lusaka Peace Agreement in 1994, has now ceased because of the donor loss of interest in the country, worsened by the return of hostilities in 1998. The NGO project, however, continues to function in a highly innovative and learning-oriented way. The explicit policy of the NGO is to support the public sector in fulfilling its role in meeting the health needs of the population in the provinces, rather than act as a direct service provider in their own right. In this way, issues of capacity building, institutional strengthening, and longer-term planning may be tested as to whether these constitute realisable outcomes within a highly unstable situation.

Suzanne Fustukian, in her presentation, described how Somaliland's Ministry of Health and Labour (MOHL) has also been effectively abandoned by major donors. Lack of international recognition for Somaliland's secession from the Federal Somali Republic in 1991, combined with several recurrences of hostilities in 1992-93 and 1994-96, has resulted in minimal international support for reconstruction. In a recent report from the government (MOHL, 1999), supported by UNDP and UNHCR as part of the development of a 'plan of action for repatriation, rehabilitation and reintegration', the MOHL noted that at central level there were: *"inadequate policy, guidelines, standards, and legislation to govern the health sector; inadequate technical and professional personnel; poor coordination of health care activities within the sector as well as among aid agencies; lack of management information systems (MIS) to monitor, regulate, plan and make strategiec decisions; and limited financial/technical capacity (including HMIS)."* However, with support and advice from UNICEF, UNHCR and UNDP, renewed efforts have been made in health policy formulation resulting in the National Health Policy of April 1999 and a five year strategic health plan. The policy document reflects normative health sector reform prescriptions, such as public/private sector provision and cooperation; collaboration and partnership between the health service and communities; coordination between government, donors, and NGOs; cost-sharing strategy; the development of an essential health care package; and decentralisation. Given the low level of government revenue (total government budget = $4.8 million) and the allocation to the MOHL of 2.4% (MOHL, 1999), there is concern that progress on these health reform components will be extremely slow, hampered by limited external funding. **Christina Zarowsky** commented that a particular challenge in Somaliland was designing appropriate health systems for nomadic populations. **Enrico Pavignani** asked how it was possible to consider health reforms with such insignificant financing, and decentralisation without either sufficient health personnel or a functional central government.

Bosnia Case Study

> *sustainability requires strengthening local capacity to mobilise internal resources and avoid long-term dependency. Duplication by donors and agencies should be avoided to ensure efficient allocation of resources, with an emphasis on a basic package of health services. Attention was also being given to various types of health insurance, both social and voluntary. (Kadic, 2000)*

In Bosnia-Herzegovina, **Alma Kadic** described health care reform as "*probably one of the most challenging tasks facing countries in transition and in a post-conflict period.*" According to the Federation's Minister of Health, Dr Bozo Ljubic, the "country's policies are 'very often imposed by international factors'" (Horton, 1999). Dr Kadic also directed attention to the decentralisation policy that divides the Federation into 10 Cantons "*with considerable autonomy.*" Imposed by the Dayton Accord in 1995, each Canton has its own parliament and Minister of Health, making coordination and equity of paramount concern (Horton, 1999). For example, "doctors and the hospitals they inhabit are not divided equally between regions (rural areas have especially poor services)" (Horton, 1999). While these problems are not only experienced in Bosnia-Herzegovina, the situation there is politically charged - comparisons between Cantons and with neighbouring countries may exacerbate real and perceived economic and social disparities (WHO, 1999:21). Dr Kadic suggested that strengthening local capacities to mobilize internal resources and minimizing duplication and maximizing coordination and cooperation among the various stakeholders is the key to sustainability. The European Office of WHO (WHO EURO) played a major policy and implementation role in Bosnia-Herzegovina following the war in chairing the 'Sectoral Task Force on Health and Social Reconstruction' (WHO, 1999:9).

The crucial issue presented by these situations is how to formulate a policy in a disrupted, disorienting environment. Local actors are stressed, insecure and usually inexperienced in conflict-related issues (they are painfully learning by doing). Outsiders can be "functionally blind to the specific conditions that confront them" (Duffield 1994). To state that a country re-emerging from conflict should formulate its own recovery plan is not enough. The point is how to help it to do it competently, sensibly and effectively. Without absorption of lessons learned in the past (in-country, as in Mozambique, or abroad), it is very unlikely that a meaningful and enforceable policy is conceived.

3. External aid and coordination

Aid coordination, particularly the lack of coordination, was a key theme in many of the presentations. A useful definition of aid coordination in the health sector is offered by Buse and Walt (1996): "*any activity or set of activities, formal or informal, at any level, undertaken by the recipient in conjunction with donors, individually or collectively, which ensures that foreign inputs to the health sector enable the health system to function more effectively and in accordance with local priorities, over time.*" For most countries emerging from conflict, the coherence, relevance and coordination of external aid and agencies are of critical importance in the reconstruction process.

Although 'post'-conflict settings have heightened needs for policy and donor coordination, with many essential but competing priorities, they may be particularly unstable and complex with reduced government capacity to manage and direct the process. Even in more stable situations, coordination of external aid is often highly contentious and disputed by a variety of stakeholders (Buse and Walt, 1996; Walt et.al., 1999). As Lanjouw et.al. (1999) point out, in relation to Cambodia's experience, "*not only do national politicians and authorities compete to set the agenda, but so too do international actors – governmental and non-governmental – frequently compete to influence the nature and priorities of the emerging 'post'-conflict state.*"

Increasingly, as conflict/'post'-conflict situations have increased and/or intensified, multilateral agencies such as the World Bank have sought to re-examine their position and policy in relation to the transitional 'post'-conflict period. In citing its own "lack of understanding of conflict–related situations and lack of experience" (World Bank, 1997), the World Bank established a specialised 'post-conflict unit' in August 1997 in order to articulate better the Bank's response to post-conflict needs. Greater effort is being taken to investigate alternative responses by the Bank to unstable and 'post'-conflict recovery situations. The presence of the Bank presented both opportunities and difficulties in several of the countries present at the Symposium, for example, East Timor and Bosnia.

Mozambique case study

The coordination of external support is essential. When the reconstruction process is dependent on donor resources and the donor community is large and variegated, such as it was in Mozambique, aid management and coordination of donor interventions deserve special attention. Strong, consistent leadership by MoH may be the essential factor to solidify donor support around shared goals. If national authorities are unable or unwilling to take the lead, an alternative body, acceptable to most, if not all players, should take the responsibility of coordinating health interventions. (Pavignani, 1999)

Egbert Sondorp was cautious of the ability of Joint Assessment Mission to East Timor to function appropriately prior to the establishment of UNTAET. With no civil authority to talk to or to find out what the UN was planning, there was little possibility for substantive consultation given the lack of local coordination mechanisms. This had an impact on the development of a policy framework and planning process. Although the emphasis on participatory policy formulation was positive, it was unclear with whom the Team were to interact or how to access different groups. How were the minimum health care packages to be designed and on the basis of whose priorities? Although international NGOs were providing much needed health care, there was no coordination of their different inputs. While WHO had a potential role to play in coordination, this proved difficult in that WHO was also a stakeholder, equally raising funds to carry out activities. WHO's role as a coordinator and neutral broker for the health sector should therefore be consistently recognised and supported. However, some participants' criticised WHO's poor record to date, while others argued that WHO is increasingly gaining the skills and insights to contribute positively in these environments, such as in Kosovo. Key roles must be earned on competence / effectiveness grounds, rather than on abstract mandates. Donor agencies are inherently unruly. **Pavignani**

indicated that when expected to follow a weak, inconsistent, and underfunded leader, other donors will not hesitate to bypass it. Participants suggested that WHO should learn that its leadership has to be backed by a credible performance if it is to become an influential player in these complex settings.

Sierra Leone Case Study

> *Most developed countries play double standards in the treatment of countries in Africa emerging from conflicts. The problems of these countries are not communicated well, as assessments are often rapid and on-the-spot by external people who rely on second-hand information. Promises are often made; but follow-up action is delayed.*
>
> *A call for more emphasis on primary health care and sanitation programs cannot be over stressed.* (Benjamin, 2000)

Although supportive of the WHO efforts to advance a policy framework for the health sector in Kosovo, **Lecaj** and **Chamberlain** considered lack of coordination between the 'formal' sector (including UNMIK and formal Kosovan institution) and NGOs a major drawback. They observed that the WHO interim policy document mentioned above, while providing a useful reference point for NGOs, had very little effect on their programming for a variety of reasons. Most NGOs were under pressure to act fast – donor funding was available for immediate projects aimed primarily at infrastructure rehabilitation and primary care development. They also suggested that many NGOs implemented programmes without thorough assessments or relied on Kosovars with little experience in needs assessment or planning, while NGOs which did produce useful data did not widely share their assessments with others. Three examples were given of the consequences of poor coordination: winterising facilities, the development of Family Medicine Centres (FMC) and training. Most NGOs were willing to support these activities but were unclear which facilities (for winterising) and 'health houses' (as FMC) had been designated. Ram Shankar pointed out that WHO, the main agency advising on the development of health policy in Kosovo, did play a critical role in moving health policy and strategy forward but was positioned outside the core UNMIK structure in an advisory capacity. This limited its ability to take on a more strategic coordinating role as this was the task of the UNMIK civil administration.

Angola Case Study

> *Humanitarian coordinators should routinely consider seeking donor cooperation for a small, quick-disbursing fund. Smaller donors are likely to be most interested in such a mechanism. Review and funding procedures must be very fast; and the terms under which funding is provided should be sufficiently flexible to allow NGOs to respond under changing circumstances.* (Pavignani and Beesley, 1999)

4. Changing relationships: state, donors, and NGOs

Issues of coordination also raised problems of changing relationships and expectations between the newly emerging authorities, whose capacity and legitimacy may still be questioned, donors and external NGOs. A complicating factor for rehabilitation efforts is a shift in the external agencies involved, from humanitarian/relief agencies to those with a development orientation, for example, from the UNHCR to the UNDP, or international humanitarian organisations such as MSF to more development oriented NGOs such as Oxfam. Often, in the 'grey' transition period, agencies of all persuasions are active, creating considerable problems in coordination, as well as revealing unclear mandates, lack of clear objectives and priorities and, frequently, short-term vs long-term planning and project horizons. The proliferation of international agencies engaged in 'post'-conflict rehabilitation is having a major impact on coordination: 129 in Bosnia and Herzegovina (Kadic), and around 150 in Kosovo (Lecaj and Chamberlain).

State authorities frequently see NGOs as disruptive partners in the rehabilitation process. Great concern is routinely expressed about their poor record of coordination, either amongst themselves or in relation to emerging state authorities, that they have a different vision of the health system from that of the incoming authority, or that they compete with each other for partners, resources, and publicity. Often, NGOs are seen as undermining the recovery process in a number of ways: adding to inequity through concentrating their resources and services in selected geographical regions; employing staff poached from the public sector; or by establishing operational standards and facilities that are unsustainable by the public sector (Pavignani, 1999; Fustukian, 1999; Lanjouw et.al. 1999).

The decision to utilise the operational capacity of NGOs, often at the expense of rebuilding the capacity of the state, is frequently taken by bilateral agencies. This is usually ascribed to a lack of operational, institutional and management capacity on the part of the state machinery but, to many analysts, reflects a political stance on the part of the bilateral donors, wary of endorsing the legitimacy of contested state authority and anxious to find quick channels for disbursing time-bound funding (Pavignani, 1999; Macrae, 1997). NGOs willing to work in cooperation with government services, however, have a significant potential to extend the reach of struggling public sector services to under-served populations, to support communities and civil society. Coordination and monitoring of this diverse group of actors is, however necessary – many may not have sufficient experience, expertise or capacity to function effectively in transitional situations. Those who do often have a potential for innovation and support for human rights and marginalised groups that makes them a credible partner in 'post'-conflict recovery.

5. Capacity building and human resources development

The development of human resources is a major challenge in 'post'-conflict settings and fundamental to the rebuilding of the health system. Major constraints in post-conflict settings are the low numbers of appropriately trained personnel at all levels of the system or scarcity of expertise at the higher level. Health workers have often been direct targets of opposing

factions during conflicts (Cliff and Noormahomed, 1988); in most cases, survivors will have fled the conflict zones for urban areas or other countries, leaving huge gaps in health coverage. Many health workers were killed during the genocide in Rwanda (Kayitare) whereas in East Timor, all senior health staff were Indonesian who withdrew following the result of the successful poll for independence (Sondorp). In Kosovo, Albanian health workers had operated in parallel non-state systems for a decade but following the NATO bombing were called upon to fill major decision-making and strategic roles.

Urgent attention therefore needs to be given to developing a human resources policy, re-establishing the human face of the system and its capacity to respond to public health needs. Attention to both public and private sectors, at local and central levels and in relation to management and technical functions is required. Improving standards of care, developing a range of training approaches sensitive to constraints and capacities, including short courses, distance-based learning, and on-the-job training, are essential strategies. Understanding how health workers survive, what motivates them, and what their coping mechanisms are for dealing with adversity may also contribute to developing more appropriate strategies for the future.

Rwanda Case Study

> *The Ministry of Health faces three key challenges: first, the development of human resources, in a context where many health workers had fled and become refugees themselves or been killed. In fact, the number of doctors has declined, from 252 in 1991 to 147 at present; second, quality assurance at all levels of the health system, within a context where quality assurance was not a priority; and, thirdly, the financing of priority services, but where the government is faced with a situation of weak and minimal public resources, and simultaneously, a reduction of external support to emergency programs.* (Kayitare, 2000)

Jerome Kayitare considered rebuilding human resources as the *"premier challenge facing Rwanda"*. Of the 250 doctors working in the health system prior to the 1994 genocide, only 60 remained afterwards. As a result, reliance on expatriate health professionals is high in the public sector. Salaries in the public service are low, significantly affecting the commitment of time given to this sector. An attempt has been made to regulate the division between public and private sector activity, with doctors expected to spend 60% in the public service and 40% in private practice. Kayitare also considers that health personnel are undertaking tasks for which they are not qualified. Much is currently being done to build capacity in management and planning, and to increase motivation to work in the public sector and improve quality.

Somaliland also faces a daunting task in human resource development. A situation analysis undertaken by the Ministry of Health and Labour highlighted a critical shortage of almost all cadres of health workers. Pay and productivity levels were low, professional standards "non-existent", and competence "self-reported". Somaliland had benefited, however, from a net gain of health workers leaving the continuing destabilisation in Somalia in the south. The government was in the process of developing a human resource policy and strategy.

The Health Transition Project in Angola, described by **Enrico Pavignani,** aims to strengthen institutional and management capacity in Benguela and Huambo provinces using a systemic approach, with a focus on integrated resource management, improved organisational practice, integrated supervision and in-service training, and budget support. The proponents of the approach clearly considered its merits – efficiency gains, boosting staff morale, context-driven, commitment to service integration, growing accountability – to offset the difficulties of working in "an unstable, disrupted environment, where stress, uncertainty and short-termism prevail" (Pavignani, 1999b).

In addition to the loss of institutional memory and capacity with the withdrawal of senior health professionals, including 160 doctors, from East Timor, **Egbert Sondorp** also explained that no planning documents were left behind to assist in rebuilding East Timor's health sector. Given the lack of educational opportunities for the Timorese under Indonesian rule, there was a significant lack of educated people for mid/senior level posts; those that were available were being employed by the UN and other agencies. An extensive training programme was urgently needed to fill higher level posts.

Kosovo Case Study

From July of 1990, the Serbian government started dismissing the Albanian medical workers. This resulted in the aggravation of the health situation in Kosovo. After 1990, many Albanians used the parallel system of primary health care, due to the mistrust in state health services. All this confusion had a tremendous impact on the fall of immunization rates and in the effectiveness of other preventive measures. (Boshnjaku, 2000)

Ismet Lecaj and **Jeannie Chamberlain** reflected on the relationship between external agencies and national health professionals in Kosovo. The perception of these agencies was that HRD was starting from a low base of skill, when locally there was a "*pool of talent in the health sector.*" This was partly explained by the historical situation that Kosovar health workers had been forced out of the formal system by the Serb Republic 10 years earlier; gaps in knowledge and practice had resulted, but this could be directly acted on with a upgrading/reorientation strategy. A number of Kosovars had also worked in the parallel system that had been established in the province. WHO had proposed that the Faculty of Medicine at the University of Pristina take the lead in providing up-dating and provision of medical education – but no funds had been provided to assist with this process; instead, WHO requested NGOs to assist with funding. NGOs, however, conduct their own training programmes without necessarily conforming to WHO's plan. There was also a competitive market for local health and other professionals between the emerging formal system, in which payment was considered inadequate, and working with NGOs and other agencies where wages were better.

Alma Kadic also recommended that donors "*should recognise and develop local strengths and expertise*" in Bosnia-Herzegovina.

A crucial challenge is to integrate health workers from warring sides into the general health system. A difficulty often faced is the disparity in schooling levels, job descriptions and

professional training. In Mozambique, RENAMO's health workers could not be integrated without passing through a long retraining programme. This was successfully designed and carried out, despite its high cost, by the MoH, thus sending a signal to the rebels about government commitment to fairness throughout the integration process (Pavignani, 1999a).

6. Promotion of equity

In the initial presentation, **Anthony Zwi** had emphasised the importance of early choices around values underpinning the health system. Issues of solidarity, quality and equity were highlighted. Disparities in health status linked to gender, age and socio-economic inequalities are often amplified by the different circumstances individuals and groups have experienced during the conflict; many of these inequalities overlap and reinforce each other. In particular, the loss of kin and social networks, a distinctive feature of recent conflicts, has had a major impact in reducing the coping capacity of socially vulnerable groups, such as women-headed households, the elderly, orphaned or abandoned children and the disabled.

During periods of conflict, men are generally absent from their households and communities, leaving women to take on a range of formerly male-dominated roles - even in highly patriarchal societies (Turshen, 1998; El Bushra and Piza-Lopez, 1994). **Henia Dakkak** commented, that even in situations where women were active as fighters during a political struggle, and cultural barriers had been broken down to some extent, women are often expected to re-assume their traditional roles in society after the conflict ends. In the post-conflict environment it has often proved difficult to maintain these gains and adaptations in gender relations: patriarchal power structures are usually retained in the post-conflict settlement, and projects infrequently address women's issues, except to focus on their reproductive health needs.

Many struggles, however, such as the Algerian, Palestinian, and Eritrean, have drawn extensively on the contribution of women – thus a major challenge confronting a new authority is ensuring that women collectively receive both recognition as well as some of the benefits from a return to peace. The post-conflict situation, and the presence of incoming development agencies, offers women opportunities to develop their organisational capacity to argue for political, legislative and social change. **Suzanne Fustukian** described the role of women in Somaliland whose role as 'clan ambassadors' has been recognised as instrumental in recent peacemaking and mediation efforts in disputes between clans. This has not been translated into political power in the new Republic of Somaliland, an issue that Somaliland women's organisations are challenging. **Christina Zarowsky** endorsed the view that women need to enter the political arena for their needs and concerns to gain political legitimacy. **Ken Bush** commented that more research is needed to understand when, why and how women can play an effective role as peacebuilders and, alternatively, when women may act as a counter-force to peace initiatives.

Somaliland Case Study

Somaliland women have always been active members of society. The civil conflicts have pushed them even more into the forefront because of health and disablement that disportportionately affected the male population, who suffered more from mental problems related to the war. The disruption of societal functions and infrastructure has also led to unemployment which more severely affected men. ... Civil war has had an incalculable effect on reproductive health, since most of the reproductive health infrastructure that existed prior to 1988 has been destroyed, thus greatly reducing access to preventive and curative services. (Ismail, 2000)

Policies and strategies aimed at enhancing equity in 'post'-conflict environments must, by necessity, be based on careful analysis and acknowledgment of the needs of different groups, arrived at with their participation, mobilising public awareness and involving strategic thinking about political obstacles (WHO, 1996). As Gilson (1998) argues, "the pursuit of equity forces consideration of decision-making procedures in society, and the extent to which they allow for broad representation and so expand choice." An equity-oriented policy needs to be considered as part of an "integrated strategic framework for political, social and economic rehabilitation" (Kumar, 1997).

7. Peacebuilding

The issue of equity is strongly linked with peacebuilding. Many inequities are deeply embedded in fragmented and divided societies and have frequently played a significant role in the genesis of conflict. The potential for renewed tension and conflict if the root causes of conflict are not addressed is therefore considerable. The inequities most prominent in sustaining a polarised society are linked to perceived group identities or membership, whether related to religion, ethnicity or political ideology (e.g. Balkans, Rwanda,Somaliland). Hence, concerns regarding horizontal equity become as important as vertical equity in these contexts. External agencies can often reinforce horizontal inequity through unequal distribution of aid to different ethnic groups: for example, the distribution of external aid to the two political entities – Federation of Bosnia-Herzegovina and Republica Srpska, created by the Dayton Agreement – was highly unequal with the former receiving 98% of external aid contributions compared with 2% to the latter in 1996 (WHO/EURO, 1999).

However, peacebuilding also has broader goals, although tackling inequity may be an important outcome. The Canadian Peacebuilding Consortium places human security at the core of their definition of peacebuilding: "the effort to promote human security in societies marked by conflict. The overarching goal of peacebuilding is to strengthen the capacity of societies to manage conflict without violence, as a means to achieve sustainable human security." Similarly, Bush (1998) defines peacebuilding as "those initiatives which foster and support sustainable structures and processes which strengthen the prospects for peaceful coexistence and decrease the likelihood of the outbreak, reoccurrence, or continuation, of violent conflict." Two approaches to 'peacebuilding' were described:

1. Peace and Conflict Impact Assessment (PCIA) instrument, developed under IDRC auspices and presented by **Ken Bush**, and
2. WHO/EURO's Peace through Health initiative in the Balkans, presented **by Gregory Hess**.

Peace and Conflict Impact Assessment (PCIA)

In the first part of his presentation, **Ken Bush** focused on more generic concepts of peacebuilding and development programming; in the second part he described the PCIA methodology. He first explained that the challenge for health professionals working in conflict-affected environments was not *to "do different things, but to do things differently."* He noted a major gap in the good intentions of agencies to support societies emerging from conflict, and possibly local capacities, and their operational principles. He contrasted current principles guiding present approaches to programming with principles that could potentially positively re-engage local actors/stakeholders:

Principles guiding present approaches	**Principles guiding future approaches**
Structured	Less structured / Unstructured
Controlled (externally)	Less controlled / Maybe uncontrolled
Predictability	Unpredictability
Product-obsessed	Process obsessed
Time-limited (bungee cord)	Open-ended
Absence	Presence
Rigidly planned	Responsive
Routine	Creative

The right hand side of the table, explained Bush, has dual goals: 1) the creation of 'space' (referred to in the introductory section of the report), and 2) giving up control. Unless external agencies can give up control, the creation of 'space' for local initiatives and capacity will be limited or non-existent; however, external aid will continue to be needed to support this process – just not their control. Iain Guest of the Overseas Development Council forcefully illustrated these issues in an article describing how the "reservoir of local talent [that] should have been the centerpiece of UNMIK's reconstruction strategy... was squandered on a foreign-driven emergency relief operation that has undermined Kosovo's indigenous capacity for recovery" (Guest, 2000). This was also emphasised in the presentation by **Ismet Lecaj** and **Jeannie Chamberlain.**

Reconciliation, described by Bush as a 'sub-set of peacebuilding', is also essential in building common interests between formerly polarised groups, based on the building of trust with an emphasis on the social and psychological.

What is generally experienced in most conflict-affected societies, **Ken Bush** suggested, is a 'mismatch' between the objectives for development projects and peacebuilding, and a failure to clearly link how the latter is integral to the former. As he explained, "a project may fail according to limited developmental criteria...but succeed according to broader peace and reconstruction criteria" (Bush, 1995). The converse is also true: "a project may succeed according to established developmental criteria but fail to have a beneficial impact on peace" (ibid.). PCIA was developed to address the dynamic links between the processes of development and peacebuilding.

Rephrased more simply, PCIA asks :

- Will/did the project foster or support sustainable structures and processes which strengthen the prospects for peaceful coexistence and decrease the likelihood of the outbreak, reoccurrence, or continuation, of violent conflict? (Bush, 1998).

Peace and Conflict Impact Assessment *is a means of evaluating (ex post facto) and anticipating (ex ante, as far as possible) the impacts of proposed and completed development projects on:*

1. *those structures and processes which strengthen the prospects for peaceful coexistence and decrease the likelihood of the outbreak, reoccurrence, or continuation, of violent conflict, and;*
2. *those structures and processes that increase the likelihood that conflict will be dealt with through violent means.*

Bush argued that PCIA should be applied in settings characterised by latent or manifest violent conflict (including 'post-conflict' or 'transition' settings) and territory that is contested or politically and legally ambiguous. [For more information on PCIA case studies, reports and toolkit, check the IDRC web site at: http://www.idrc.ca/peace/].

Peace through Health

Gregory Hess described a major initiative in Bosnia-Herzegovina, which aimed at integrating 'health development and conflict resolution' through the 'Peace through Health Programme' (PTH). The PTH programme was developed by the Partnerships in Health and Emergency Assistance unit of WHO EURO, with the support of the UK Department for International Development (DfID). The two statements below reflect the values underlying the programme:

1. "the role of the health sector in conflict situations cannot be limited to the provision of health care, and, by extension, WHO in its leadership capacity cannot be limited to its traditional normative role" (WHO/EURO, 1999: p. 40).
2. WHO adopted a "position of neutrality:... under no circumstances should accepted basic standards of health be sacrificed to achieve political gains. WHO would work on all sides according to needs and advocate against sanctions (formal or informal) which create detrimental conditions compromising accepted basic health standards" (ibid: p.21).

The PTH principles and strategies

- Primary responsibility is health
- Work on all sides, openly and transparently
- Enlist the support of health authorities
- Support for multi-track diplomacy and initiatives
- Work according to geographic boundaries, not political ones
- Work with partners
- Provide comfortable, neutral environments
- Provide opportunities for establishing internal links
- Create external links
- Foster and empower responsibility for health and environment
- Address human rights and ethics through health
- Public information and media
- Multi-sectoral approaches
- Patience and perseverance

A Peacebuilding team was established in the field with health professionals and conflict analyst specialists. Together they asked – **'how are we contributing to or exacerbating the roots of conflict?'** They identified six conditions that prevented the development of a democratic civil society: polarisation, discrimination, isolation, manipulation of information, violence, and the centralisation of power and authority. On the basis of this analysis, the field staff re-oriented the health programme within a larger framework to produce potential peacebuilding outcomes, based on the following principles and strategies:

In subsequent evaluations, PTH has appeared to have had a positive impact on policy formulation and implementation in a number of areas, including:

- reduced polarization between nationalist groups around health concerns, through opened lines of communication, including countrywide networks around health issues;
- more openness and transparency around health information, and the resumption of public health monitoring;
- inter-entity training workshops and seminars held
- growing number of independent cross-community activities and inter-entity collaboration.

Many of these advances, Hess argued, were small but necessary steps, with setbacks and new problems occurring in the wider context.

Anthony Zwi drew attention to the evaluation he and colleagues (Large et.al. 1999) had undertaken of Health as a Bridge to Peace activities in Eastern Slavonia, now in Croatia but formerly annexed by Serbia. The evaluation highlighted the sensitivity with which seemingly neutral activities such as immunisation and war trauma rehabilitation must be handled. If mishandled, such activities can exacerbate rather than reduce tensions between affected communities.

8. Participant Discussion

The two presentations generated much discussion around several issues:

Predictability vs unpredictability:
Anthony Zwi questioned whether unpredictability was a positive feature in transitional situations, arguing that people needed some control over the environment in order to move forward. **Enrico Pavignani** suggested that in highly irrational situations, structure and predictability may be sought in order to maintain sanity. Hence, unstructured approaches, not offering predictable outputs, would not look appealing to stressed actors. Only seasoned relief / conflict practitioners might feel at ease with these approaches. **Djenana Jalovcic** agreed: following the Bosnian conflict, people wanted more structure, more control and more predictability. The desire was for a product-oriented outcome, with visible results to be sustainable.

Transferring control:
Christina Zarowsky raised the problem of countries, such as Mozambique, in which there is a heavy reliance on crisis management, with little capacity in relation to long-term management issues - hence a transfer of control by donors is unlikely.
John Sullivan was also concerned by a hastily organised hand over – this process needs to be carefully thought through with questions such as 'who are you handing over to?' being addressed.

Acting on the conditions

John Sullivan highlighted the importance of Greg Hess's presentation of the six conditions that prevent the development of democratic civil society. Such conditions are found in many situations, for example, Colombia where systems are slowly collapsing. Often the public health system is the last to collapse, but when the health system disappears or when health professionals provide differential treatment to one faction or side, this signals serious failure.

Space:

Suzanne Fustukian mentioned an NGO project in Guatemala working with the Maya K'iche community in the NW Highlands. Because health projects were considered less political than community development by the authorities, a health training project was established which was intended to create 'space' and opportunity for local people to reflect on their lives, and re-connect with their Mayan identity.

John Sullivan commented that health is frequently viewed as a neutral and impartial space, for example, the International Committee of the Red Cross (ICRC) principles of neutrality and impartiality have allowed it to go in and come out of active conflict zones with relative safety. This is increasingly contested, however.

Henia Dakkak described the support from the CPHA in West Bank and Gaza to enable Palestinian public health professionals to "step out of the struggle, bring different disciplines together and ask questions such as 'what do we want to do', 'where should public health/health systems be going'? The outcome may not be obvious but it is helpful for people to come together to share perceptions across a range of disciplines.

Language and application:

Theresa Benjamin and Beverly Carrick suggested the need to demystify the approach to make it more widely accessible to non-academics and field workers. Questions were also raised about whether the PCIA approach has been piloted and evaluated? Does a case study exist that has been costed and evaluated? **Alma Kadic** commented that before starting this approach, people with expertise would need to go to specific countries to advise on its use.

Research

Almost all participants urged the linking up of practitioners and academics to undertake applied research around peacebuilding and other issues that had come up during the Symposium. **Henia Dakkak** suggested that a link between the field and an academic institution would be useful to document process and analyse potential outcomes and impact of field-based projects. **Enrico Pavignani** agreed that applied research was the best way to provide useful information. He noted that, despite our best intentions, there was very little 'collective learning'. For example, Kosova could have learnt from Mozambique re: its experience with NGOs; other's could share their experience re: what kind of information would be the most relevant in the early stages of rehabilitation. He urged a commitment to document the process – while it may be context specific, it might also be useful to someone else; but also need to avoid being so abstract that it is not of much use to anyone. However, while it is important to launch meaningful research, need to ensure that lessons are fed into future situations. The initiative by the LSHTM and CPHA remains very committed to facilitating such research, documentation, analysis, and dissemination of good practice.

Selected comments from donors

Representatives from donor agencies present were asked to comment on issues emerging from the Symposium.

Christina Zarowsky (IDRC) suggested that the dominant focus in 'post'-conflict health sector reconstruction continues to be on rebuilding health systems, with an emphasis on physical health over psycho-social health needs. What was needed in these fragile situations was a much slower, organic process that had the potential of identifying alternative forms of response: looking at health issues from a non-health perspective, and vice versa. More research was needed on donor influences and behaviour and aid effectiveness. Different questions needed to be asked in these situations, particularly in relation to the 'trauma industry' – which tends to pathologise mental health needs unnecessarily. The role of civil society also requires more attention as they play a major but often overlooked role in 'post'-conflict situations.

Necla Tschirgi (IDRC) commented that 'post'-conflict peacebuilding and reconstruction was qualitatively different from other situations: normative functional/technical responses are wholly inadequate since the problems are inter-related. Greater understanding of the context is required, particularly about how interventions will interact and influence highly politicised and sensitive systems and relationships.

Gregory Hess (WHO/EURO) contrasted the use of traditional health indicators with those based on needs as defined by vulnerability and human security. Traditional health indicators, he suggested, start with the needs of the system, leading to the identification of system interventions in the form of vertical/technical programmes: these result in 'easy' labels and boxes for donors and implementing agencies to assess and evaluate. A needs based approach starts with the needs of the people at the centre, from which an integrated approach, including but not solely concerned with the health system, can be developed: this encourages flexible, longer term approaches.

Adele Shaughnessy (CIDA) commented that CIDA was committed to creating inter-ethnic dialogue between health professionals and wider equity concerns within the health system in Kosovo. The role of international agencies should be to work within the WHO framework with a long-term perspective. However, she urged recognition that, despite commitment to innovative and flexible approaches on the ground, a complicated bureaucratic process still needs to be followed to mobilise funds for such work.

Bill Lyerly (USAID) observed that much discussion has been focused on the 'relief-development continuum', highlighting the "big moat" that exists between relief and development actors. In USAID, such bureaucratic compartmentalisation had been the subject of internal review, with the result that the Division of Crisis Mitigation and Recovery has been placed within the Office of Sustainable Development and funds conflict prevention/resolution activities in addition to emergency/recovery activities. He also suggested that **human security** as defined by the UNDP (1994) transcends the 'continuum' and offers a core concept for developing relevant and appropriate responses to all dimensions of conflict-affected, post-conflict and more stable societies.

Human security

The United Nations 1994 Human Development Report defines human security as "the sense that people are free from worries, not merely from the dread of a cataclysmic world event but primarily about daily life. Human security is people-centered while being tuned to two different aspects: It means, first, safety from such chronic threats of hunger, disease and repression. And second, it means protection from sudden and hurtful disruption in the patterns of daily life – whether in homes, in job or in communities."

He drew attention to the work of CERTI, the 'Complex Emergency Response and Transition Initiative', an interagency initiative, partly funded by USAID:

> CERTI addresses the "challenges of programming international assistance to achieve health security within the context of increasingly frequent and severe conflict-related crises (complex emergencies) in Sub-Saharan Africa (SSA)." The CERTI framework "recognizes that important organizational actors within the African context include international donor agencies, international implementing agencies, regional institutions, local governments, civil society groups, academia, and military groups... Four principal strategies are identified which will enhance the transition from conflict/chaos to sustainable development. The first of these strategies includes the investment of development resources to address the causes of conflict such as inequity and the lack of a foundation for civil society. A second strategy is the development of early warning and conflict resolution/management strategies to more effectively channel conflict to productive solutions. Thirdly, relief response should be strengthened and enhanced to ensure professionalism and "development smart" interventions that are supportive to rather than competitive with long term development goals. Finally, the strategy component entails the design and support of effective "transition" programs that facilitate the peace process while addressing the special developmental needs of populations emerging from the trauma and devastation of war." (CERTI website: http://www.certi.org)

CERTI's approach is multi-disciplinary and inter-sectoral, with the following anticipated outputs:

- Optimize the assets of governmental, non-governmental, civil society and military organizations
- Recognize the importance of institutional change among donor and implementing international organizations
- Recognize crisis as an integral feature of a societal dynamic and not merely a "relief" problem
- Health outcome driven: Health as a benchmark as well as a key input

9. Workshop discussion around research objectives and priorities

Anthony Zwi introduced LSHTM proposals for taking forward a programme of action-research around health and post-conflict health system development. He briefly outlined proposed objectives and guiding principles for a research programme and offered some ideas for discussion within groups.

Among the objectives developed when planning the meeting, the following were research-focused:

1. To develop a research agenda which would facilitate the development of effective partnerships between country personnel, research groups, NGOs and donor organizations.
2. To identify key partners (country personnel, academics, donors) willing to participate in and support this initiative.
3. To widen the participation in post-conflict health policy research beyond those currently engaged in these activities; in particular to encourage and facilitate Canadian involvement in this initiative.
4. To work towards the development of a set of policy and planning tools which are well suited to application in post-conflict settings.

A range of ambitious meeting outputs had been identified prior to the meeting; a number of these were discussed at the workshop.

1. To develop an agreed framework for the research and related activities.
2. To define key questions to be answered through each of the main elements of the research.
3. To establish at least two research partnerships between two or more committed academic, southern partners, NGOs and donors established.
4. To suggest a timetable and objectives for research activity including finalising partners and mobilising additional research teams and funds.
5. To stimulate increased interest and attention to post-conflict health policy issues.

Objectives 2 and 5 were achieved to an extent, while objectives 1, 3 and 4 are currently being followed up the LSHTM with interested partners.

Research framework

A number of guiding principles were identified as underlying the research activities:

1. Southern voices and experience should be clearly heard.
2. Efforts must be made to support the capacity of southern institutions, including local and national government, to participate in and to actively influence these processes.
3. The development of assessment tools, guidelines, policy advice and other usable materials should be key outputs of the research activity.
4. Learning lessons and identifying good practice is central to avoiding the same mistakes being made time and again.

A research framework was suggested which builds upon earlier work undertaken through the London School of Hygiene and Tropical Medicine, but extends beyond this. The LSHTM team were particularly keen to share ideas around an action research agenda, and to identify partnerships which together could take this agenda forward. In particular, the initiative proposed to place country concerns at the centre and to examine the mechanisms for supporting the development of local capacity to manage the complex period of transition after major conflicts. A key objective was seen as not only drawing together experiences from affected countries, but refining our understanding of how these periods of complexity are

conceptualised, how they can be analysed, and how decisions taken during this period can be improved and informed by appropriate forms of evidence in order to increase the likelihood of successful implementation.

Within the group discussions it was clear that issues related *to generate understanding of 'good practice'* (what is it? How can it be defined? Who determines what is good practice?), identifying contributors to achieving good practice, developing tools, methods and guidelines which are of use in promoting good practice, and making insights and experience available through networks and dissemination of good practice were all seen as key objectives. Lessons from both positive and negative examples were deemed of interest. Of particular interest to both field practitioners and donors was the need to make effective arguments regarding alternative approaches and to provide practical guidance that is evidence-based – i.e., there is a need to operationalise lessons and critiques from research.

The research framework proposes to establish *linkages* between post-conflict countries and international organisations and academic institutions. Table 1 highlights aspects of current experience in relation to post-conflict countries and sheds light on a number of key questions around which experience, expertise, tools and documented evidence are lacking. This project will contribute to resolving these inadequacies of current experience and documentation.

Figure 1 suggests how a series of *partnerships* focused on tackling key research patterns could be established, to answer the key questions identified in the middle of the diagram. Additional countries and partnerships could be added when ready. Lines of learning can be established between countries, between different actors within and outside affected countries, and between the academic, NGO and ministry of health communities.

The research project as conceptualised will have both *retrospective and prospective components.* The retrospective elements will be applicable to all countries participating and will require the development of an understanding of the conflict, the health system and the post-conflict transition.

Group discussion highlighted the importance of defining appropriate endpoints for health-related work in post-conflict countries. All agreed that a healthier, more peaceful and equitable society was desirable, and discussion focused on the relative importance of *peace and health*, *peace through health*, or *health through peace*. Approaches to defining a desirable endpoint, and to contributing ways of getting there, deserve attention in any research undertaken. There was considerable support for focusing more widely than on health care alone through this project.

Key Research Issues

Key issues highlighted for exploration included the following:

- To what extent has an effective overarching ***policy framework*** been established for guiding health system development? How was this framework identified? Who contributed to it? Through what processes? What are the main elements of the future health system? Who has put forward the dominant vision for the system? Do other visions/alternatives exist?

To what extent are issues of solidarity, sustainability, efficiency and equity addressed? What has been the role of international donors, health professionals and their associations, NGOs and academic institutions? Who 'owns' and leads the process(es)? How open and transparent is the process and how consultative is it? Do international agencies facilitate the opening of space for dialogue or do they close it down? To what extent is there evidence that experience from elsewhere was utilised in establishing this policy framework? How was/can this information be made more widely available at critical points?

- In what ways have the ***roles of key actors*** changed over this period of transition? What are their interests, goals, agendas and capabilities? How well do these fit in with locally identified needs and priorities? In particular, what have been the changing roles of ***national and local government***, donors, WHO and World Bank, NGOs (local and international), and academics. A particular interest will be to understand the emergence of the ***private sector*** and policies governing relationships with this sector. The changing relationships between state and *NGO* raise similarly important issues. Exploring the role of ***professional associations*** in contributing to policy debate and in framing key policy objectives in relation to human resources was also briefly highlighted. A particular interest was also expressed to examine the ***role of transitional authorities*** such as UNTAET in Timor and UNMIK in Kosovo. The role of *WHO* was also felt to warrant particular emphasis. Issues of ***coordination*** and partnership immediately spring from an analysis of key actors and the relationships between them.

- To what extent has ***equity*** been placed upon the agenda? If so, whose conception of equity? Which issues have been identified as important to address? To what extent have efforts been made to overcome some of the contributors to the original conflict? To what extent has gender equity been identified as important and how is this to be addressed in society and within the health sector? Has the health sector role been identified as offering potential to build bridges between communities and to reduce tensions and conflict between groups? In what way have such programs been proposed and what evidence exists documenting their impact and influence?

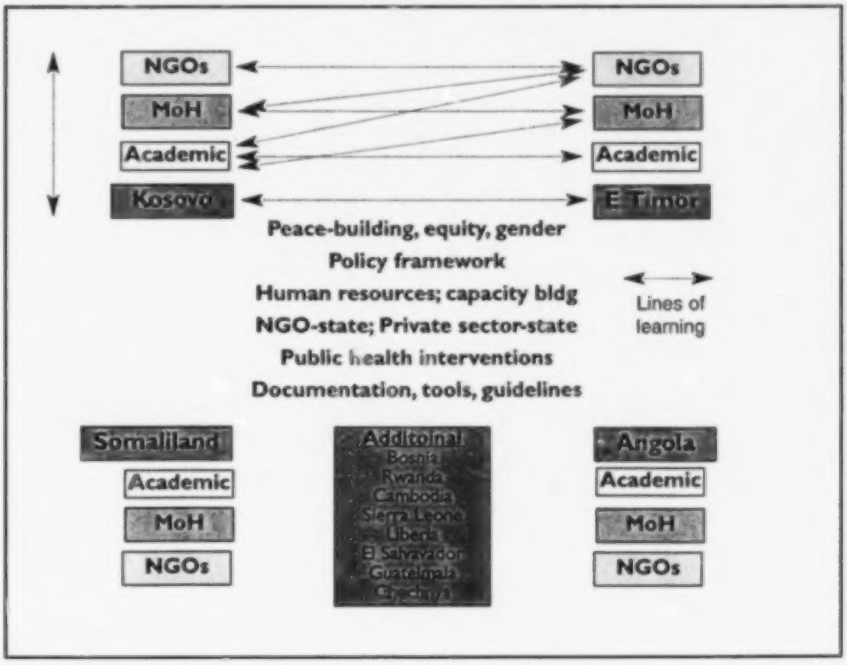
- Extent to which ***peace-building*** is identified as an explicit objective? To what extent have health-related activities been promoted as peace-building opportunities? What is the extent of priority on security issues as opposed to more narrowly defined 'health' issues? Where do these two concepts overlap? Highlight an emphasis on conceptualising a 'human security' framework and ways it could work operationally. To what extent has the way in which health system developments have been undertaken contributed to, or undermined, peace-building activities? What linkages have been established between those working in the health sector and those operating at a broader developmental and peace-building role? A related concern was the way in which positive social-capital has been identified and supported through post-conflict activities and initiatives.

- What is the ***role of information in influencing policy*** decisions? What types of information, collected by whom, for what purpose, with what degree of precision and validity? To what extent are key decisions relating to the above determined on the basis of accurate information and which not? What *tools* have been used by key actors to

understand the situation, analyse it and predict possible consequences? How can these tools be further enhanced so as to inform needs assessment and policy decision-making in the future? One area in which tools are especially needed are in relation to assessing ***financing capabilities***, and longer-term sustainability of the community, government and donor community. What mechanisms have been employed to ***exchange, share and develop the information base*** on which policy decisions should be made? Another key area for the development of tools was the establishment of rapid assessment methods to determine local capabilities and capacities - in terms of health services, health care providers, and health policy formulation and implementation.

One approach to tackling these much larger over-arching themes would be to focus on some key ***tracer areas*** of activity. One area suggested, of particular interest to Queens University, is the issue of ***community-based rehabilitation***, both physical and psychological. *Disease control* was another possibility, as was ***human resource*** policy. It was also felt important that research should reflect the perspective of both internal and external concerns. In particular, learning about how good practice is distilled was deemed important, who defines the outcomes and who defines the desirable impacts and quality levels for work undertaken in the transition period. Links between health sector activity and that taking place in other sectors will be sought.

Understanding how questions are phrased and framed, and how solutions are to be sought will be important to examine within the research undertaken, but is also relevant to the research process we ourselves will be undertaking. Ensuring a high degree of local ownership and participation will greatly enhance the value of the project and ensure that beyond key questions which may form the core of the comparative elements of the project, there is considerable scope for additional dimensions to be developed to reflect specific concerns.



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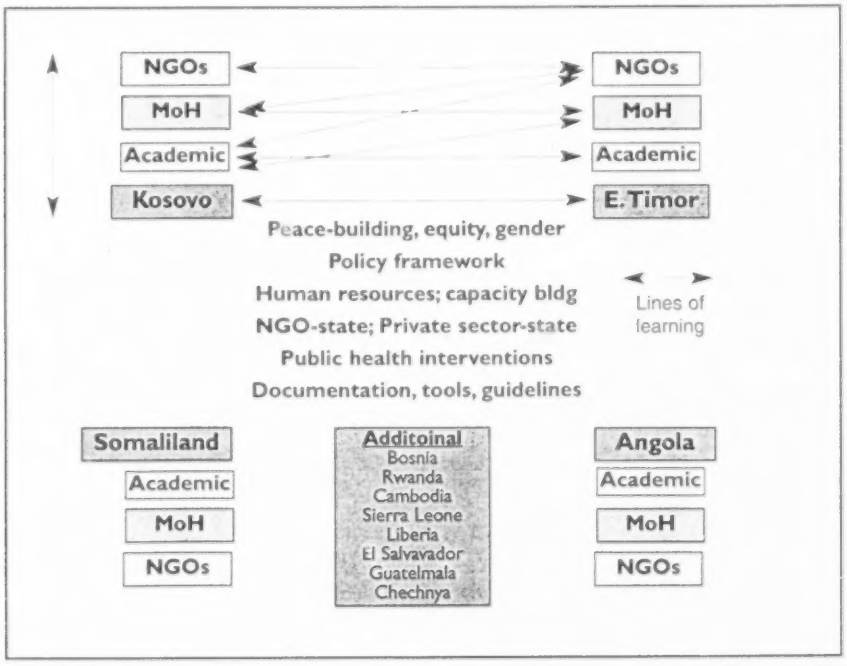


The LSHTM team has been, and remains keen to undertake a prospective study in Kosovo, East Timor, Somaliland, Angola and possibly Bosnia, in order to monitor, in an ongoing way, the dimensions highlighted above. It was suggested that the research cover a sufficient range of case studies to demonstrate *variations between contexts*, but that it not undertaken too many case studies to make it unwieldy and infeasible. The rationale for a *prospective study* was that it would be possible to focus on the immediate emergency and response to it, identify changes which had taken place in the year or two thereafter, and that one could also look at longer-term post-emergency developments (3-5 years; revealing insights in terms of reconciliation and development). It was felt that such analyses would be more insightful than cross-sectional studies at a single point in time in the evolution of post-conflict response. Tracer policies and cross-cutting themes could be examined over these transitional periods. The project will also seek to identify how we know which phase we're in at a point in time, and what the implications are of seeing continuity or dichotomies between phases.

Additional countries which will be invited to participate by contributing analyses and experience will include:

1. Rwanda
2. Cambodia
3. Sierra Leone
4. Liberia
5. El Salvador
6. Guatemala
7. Chechnya

It is envisaged that additional partner institutions will join the initiative and undertake to establish an active partnership with one or more of these countries. Through the network and collaborative research process ideas will be exchanged and a common framework pursued.

Audiences for the action-research and knowledge generation activities were identified and included the following:

- Country level: Ministry of Health, local institutions, programme managers, professional organisations, research groups
- NGOs: international and local
- Donors: local and international

The meeting agreed that key objectives for all such activity were to:

- Generate understanding of what constitutes good practice
- Identify contributors to achieving good practice
- Develop tools, methods and guidelines of value in promoting good practice
- Make insights available through networking and sharing

10. Other proposed activities

It is important to ***establish what other initiatives exist*** in this field and to ensure complementarity between them. Two identified areas of complementarity include the CERTI initiative which has been supported by USAID but has wide membership open to those interested, and the World Bank post-conflict initiative.

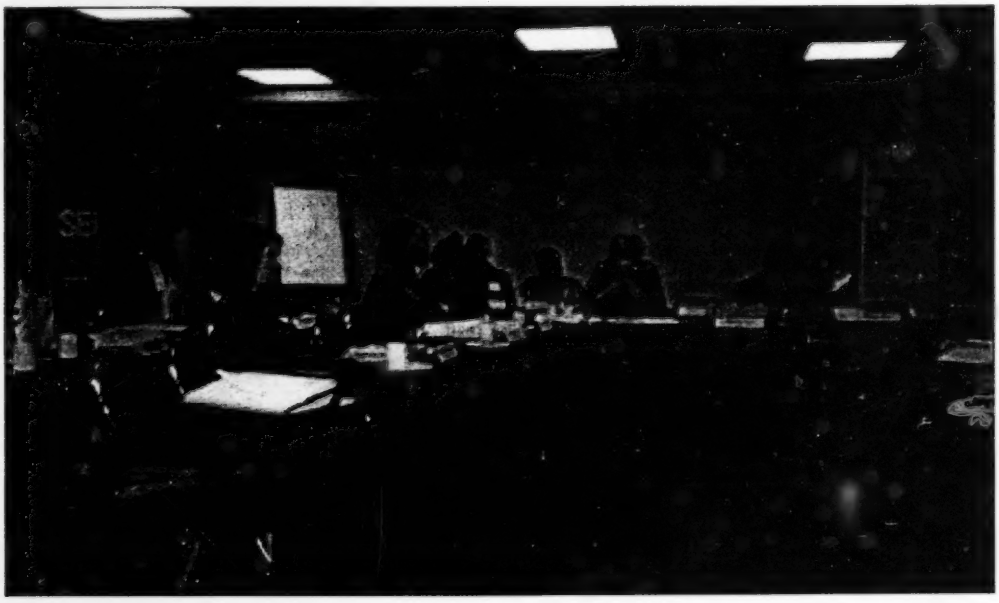
The LSHTM team is committed to producing an ***edited book*** to reflect current health and health system needs, analyses and experiences in post-conflict countries. Funding support is to be sought over the coming months.

The meeting discussed the establishment of a ***web-site*** and ***virtual network*** of researchers and others interested in maintaining links around post-conflict health policy development. This web-site could house ongoing analyses and assessments from different countries plus make available tools, guidelines and policy documents for perusal.

A number of ***meetings*** were identified as worth following up. One of the themes at the *Social Science and Medicine* meeting to be held in the Netherlands in October will be around post-conflict health system development. *The Canadian Society for International Health* will be meeting in November and a session on post-conflict would fit in well with the programme. It was also suggested that the next meeting of the developing network be held in a post-conflict country, possibly Kosovo, Bosnia or Cambodia.

We should consider the ***advocacy role*** of the group in order to take forward what we begin to identify as good practice. The role to be played by national and international NGOs and professional associations, such as national public health associations, should be explored, to determine how best to maximize their effectiveness in this process.

While the LSHTM will take forward specific proposals in relation to these activities, all present were encouraged to see these activities as common with an agenda which was unfolding and being refined and further developed based upon expressed interests and concerns. Sharing or pooling of ideas and planning for action research, based on the issues raised at the Symposium, would be most welcome by both organising institutions: the Canadian Public Health Association and the London School of Hygiene and Tropical Medicine.



References

Barnes, S. 1998. "NGOs in peace-keeping operations: their role in Mozambique," *Development in Practice*, Vol. 8, no. 3 August 1998: 309-322.

Bush, K. 1998. *A Measure of Peace: Peace and Conflict Impact Assessment (PCIA) of Development Projects in Conflict Zones.* Working Paper no. 1. The Peacebuilding and Reconstruction Program Initiative and the Evaluation Unit, International Development Research Centre. Ottawa, IDRC.

Bush, K. 1995. "Towards a balanced approach to rebuilding war-torn societies," *Canadian Foreign Policy*, Vol. 3, no. 3: 49-69.

Buse, K. and G. Walt. 1996. "Aid coordination for health sector reform: a conceptual framework for analysis and assessment," *Health Policy*, Vol. 38: 173-187.

Cliffe, L. and R. Luckham. 1999. "Complex political emergencies and the state: failure and the fate of the state," *Third World Quarterly*, Vol. 20, no. 1: 27-50.

Collinson, S. 1999. *Globalisation and the dynamics of international migration: implications for the refugee regime.* New Issues in Refugee Research, Working Paper no. 1. Geneva, Centre for Documentation and Research, UNHCR. [http://www.unhcr.ch/refworld/pubs/pubon.htm]

Cliff, J. and A.R. Noormahomed. 1988. "Health as a target: South Africa's destabilisation in Mozambique," *Social Science and Medicine*, Vol. 27: 717-722

Duffield M. 1994. *Complex political emergencies: With reference to Angola and Bosnia, an exploratory report for UNICEF.*

El Bushra, J. and E. Piza-Lopez. (1994). "Gender, war and food," in Macrae, J. and A. Zwi. (Eds) *War and Hunger: Rethinking International Responses to Complex Emergencies.* London, Zed Books Ltd.

Fustukian, S. 1999. "Promoting equity as a strategy for renewal." Presentation at 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999. Unpublished.

Gilson, L. 1998. "In defence and pursuit of equity," *Social Science and Medicine*, Vol. 47, no. 12: 1891 – 1896.

Guest, I. 2000. "Misplaced charity undermines Kosovo's self-reliance," *ODC Viewpoint*, February 2000. Washington, D.C., Overseas Development Council.

Horton, R. 1999. "Croatia and Bosnia: the imprints of war – II. Restoration," *The Lancet*, Vol. 353: 2223-28.

Kumar, K. 1997. "The nature and focus of international assistance for rebuilding war-torn societies," in Kumar, K. (ed). *Rebuilding Societies after Civil War; Critical roles for international assistance.* Boulder, Lynne Reinner Publishers.

Lanjouw, S. et.al. 1999. "The role of external support for health services rehabilitation in 'post'-conflict Cambodia." Unpublished.

Large, J. et.al. 1999. Evaluation study post-war health sector transition in Eastern Slavonia (1995-1998). WHO, Emergency and Humanitarian Affairs, Health as a Bridge to Peace. [http://www.who.int/eha/trares/hbp/eslov/index.htm]

Macrae, J. 1997. "Dilemmas of legitimacy, sustainability and coherence: Rehabilitating the health sector," in Kumar, K. (Ed) *Rebuilding societies after civil war. Critical roles for international assistance.* London, Lynne Rienner Publishers.

Macrae, J. et.al. 1995. "Aid policy in transition: a preliminary analysis of 'post'-conflict rehabilitation of the health sector," *Journal of International Development*, Vol. 7, no. 4: 669-684.

Pavignani, E. 1999a. "The reconstruction process of the health sector in Mozambique - a messy affair with a happy end?" Paper prepared for 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999. Unpublished manuscript.

Pavignani, E. 1999b. "The Health Transition Project 1995-1999; the SCF intervention in Benguela and Huambo provinces. An overview." Report for the Save the children Fund (UK). September 1999. Unpublished.

Somaliland Ministry of Health and Labour. 1999. The National Health Policy.

Summerfield, D. 1995. "Assisting survivors of war and atrocity: short notes on 'psychosocial' issues for NGO workers," Unpublished paper for the Medical Foundation for the Care of Victims of Torture, London.

Turshen, M. "Women's war stories," in Turshen, M. and C. Twagiramariya (editors) *What women do in wartime: gender and conflict in Africa.* London, Zed Books.

UNDP. 1994. Human Development Report. Oxford, Oxford University Press.

UNMIK. 1999. UN Civil Administration, Health and Social Services. Interim Health Policy Guidelines for Kosova and Six Month Action Plan. September 1999.

UNMIK. 2000. UN Interim Administration Mission in Kosovo, Status Report, 10 May 2000. (http://www.un.org/peace/kosovo/pages/kosovo_status.htm)

Walt, G. et.al. 1999. "Health sector development: from aid coordination to resource management," *Health Policy and Planning*, Vol. 14,no. 3: 207-218.

WHO. 1998. *Health Strategic Response: relief, rehabilitation and development.* Report from a meeting, 18-19 June 1998. Geneva, WHO Division of Emergency and Humanitarian Action

WHO/EHA, 1997. *Report on the First World Health Organization Consultative Meeting on Health as a Bridge for Peace.* Les Pensieres, Annecy 30-31 October 1997.

WHO. 1996. *Equity in health and health care: a WHO/SIDA initiative.* Geneva, WHO (WHO/ARA/96.1) .

WHO/EURO. 1999. *WHO/DFID Peace through Health Programme.* A case study. Prepared by the WHO Field Team in Bosnia and Herzegovina, September 1998. Partnerships in Health and Emergency Assistance, WHO Regional Office for Europe.

World Bank 1998. *Post-conflict reconstruction. The role of the World Bank.* Washington, World Bank.

World Bank. 1997. *A framework for World Bank involvement in situations of conflict.* Report to the World Bank Executive Directors' Meeting, January 1997. Unpublished.

Zwi, A. et.al. forthcoming. Challenge, opportunity and danger: reconstructing health sectors after significant periods of conflict.

APPENDIX 1

Symposium on Post-Conflict Health and Health Systems: Issues and Challenges

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APPENDIX 2

Post-conflict workshops — 1998/1999

April 1998 workshop

In April 1998, a meeting was held at the London School of Hygiene and Tropical Medicine (LSHTM) to explore the challenges and opportunities in the 'post'-conflict health sector. The meeting, attended by 25 experienced professionals in health policy and planning in post-conflict situations, identified several strategic areas that need to be addressed by countries emerging from conflict:

- a need to maximise the inputs from international donors to the formulation and development of health policy;
- a process to support the development of a clear conceptual framework to guide health system development as countries emerge from conflict; this should be informed by multidisciplinary approaches to understanding the wider context and consequences for health;
- involvement of a wide range of stakeholders in a participatory and transparent process to identify needs and priorities and consider alternative models and approaches to health system development;
- greater clarity regarding the potential opportunities, limitations and constraints operating upon the range of different stakeholders (government at central and local level, UN agencies, NGOs, traditional, public and private sector providers) in financing, providing and overseeing health service provision;
- the need to promote evidence-based policy and planning to ensure that more good than harm results from interventions proposed and that resources are used as equitably and efficiently as possible.

As an outcome of the workshop, a process was put in place to take forward further study and consideration of these issues, to include both those who attended the April 1998 workshop and an invitation to a wider group of researchers and representatives from the countries undergoing recovery to participate. A proposal with three consecutive phases was developed during the April 1998 meeting with input from all the participants.

Phase I: July 1998 - February 1999

The objectives of the initial phase were to identify key themes and gaps emerging from the existing literature and commissioned case studies, to identify other relevant initiatives in this area, and to organise a two day meeting in London of steering committee members to decide on next steps. The key outputs of the initial phase were to:

- produce a brief report describing key themes and issues emerging from the literature
- commission a set of country and issue papers which could inform the next phases of the proposed project
- produce an inventory of relevant initiatives in this area
- produce a draft proposal of the key areas identified and agreed by the steering committee at a meeting organised by the LSHTM.
- The World Bank provided funding for the first stage of the proposal. Coordination and planning for this phase was extended, with the Bank's approval (letter of 20 November 1998) from end October to early February 1999.

In preparation for the meeting on the 4-5 February 1999, a series of issue papers were commissioned from selected authors, some of whom had been participants in the April 1998 workshop.

February 1999 workshop:

The second workshop on *Post-conflict health policy and planning frameworks*, organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine (LSHTM), was held in London on the 4-5 February, 1999. The objectives of the meeting were:

- to examine the issues and challenges related to health and health sector interventions in post-conflict situations, in part based on those identified in the commissioned case studies;
- to determine the potential direction and process for further collaboration in research and policy development.

The participants at the workshop included representatives of multilateral agencies, NGO headquarter and field staff, and academics; four of the participants were members of the project steering committee, set up in April 1998. Eleven case studies were presented, plus two contributions from agency representatives of the World Bank and WHO. Of the eleven, eight authors attended the meeting and presented their papers.

List of papers/presentations prepared and/or presented:

Birch, M. 1998. "*Background and rationale for the continuation of the Health Transition Programme, Angola.*" Report to the Save the Children Fund (UK), November 1998.

Chauvin, J. n.d. *"The Canadian viewpoint: current policy and future directions for the 'post'-conflict health sector."* Paper prepared for 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999.

Fustukian, S. n.d. "Promoting equity as a strategy for renewal." Presentation at 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999.

Humblet, P. and M. Biot. n.d. "*MSF Programmes in Post-conflict situations.*" Paper prepared for 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999.

Lakshminarayana, R. n.d. "Post-conflict reconstruction and the World Bank." Presentation at 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999.

Lanjouw, S., Macrae, J. and A. Zwi. n.d. "*Cambodia and 'post'-conflict rehabilitation of health services: coordination in chronic political emergencies."* Presentation at 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999. (Published in Health Policy and Planning, Vol. 14, no.3, September 1999).

Pavignani, E. (n.d.) "*The reconstruction process of the health sector in Mozambique - a messy affair with a happy end?"* Paper prepared for 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999.

Sadana, R. n.d. "Promoting evidence based policy in post-conflict settings: good practice in gathering information on health status." Presentation at 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999.

Sondorp, E. n.d. "*Challenge from relief to development - HealthNet International.*" Paper prepared for 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999.

Soyibo, A. *"'Post'-conflict health* policy and planning in West Africa: what roles for ECOWAS and regional health institutions?" Paper prepared for 'Post-conflict health policy and planning workshop', organised by the Health Policy Unit, London School of Hygiene and Tropical Medicine, 4-5 February 1999.

APPENDIX 3

Symposium on Post-Conflict Health and Health Systems: Issues and Challenges

March 19 - 21, 2000
Ottawa, Canada

Agenda

Sunday, March 19, 2000

12h30 - 13h00:	Registration
13h00 - 13h15:	Welcoming Remarks by Margaret Hilson, Director/International Programs, Canadian Public Health Association
13h15 - 13h45:	Brief self-introduction of participants
13h45 - 14h45:	Overview of the Symposium: Objectives, Background, Bringing Everyone up to Speed (Anthony Zwi and Suzanne Fustukian, LSHTM)
14h45 - 15h00:	Nutrition Break
15h00 - 16h30:	Voices from post-conflict countries: lessons learned and challenges to effective health planning and policy formulation • Mozambique • Angola • Sierra Leone
16h30 - 17h00:	Q & A period
17h00 - 17h30:	Wrap-up and next steps for tomorrow (A. Zwi or J. Chauvin)

Monday, March 20, 2000

08h30 - 08h45:	Coffee
08h45 - 10h15:	Voices from post-conflict countries: lessons learned and challenges to effective health planning and policy formulation • Rwanda • Kosovo • Bosnia
10h15 - 10h30:	Nutrition Break

10h30 – 11h30: Voices from post-conflict countries: lessons learned and challenges to effective health planning and policy formulation
- East Timor
- Somaliland

11h30 - 12h00: Q & A period

12h00 - 13h00: Lunch (at Symposium)

13h00 - 15h00: Responses to Key Issues:
- WHO
- World Bank
- CIDA and/or IDRC
- USAID
- Various academics

15h00 - 15h15: Nutrition Break

15h15 - 17h00: Peace and Conflict Impact Assessment: an overview (Kenneth Bush)

19h00: dinner hosted by CPHA

Tuesday, March 21, 2000

08h30 - 08h45: Coffee

08h45 - 10h00: Plenary session on Setting the Research Framework: presentation of process for developing country-based applied research agendas/frameworks - developing the protocol, searching for funding support

What are the issues for research? A. Zwi

10h00 - 10h15: Nutrition Break

10h15 - 12h00: Country-based working groups develop applied research frameworks

12h00 - 12h45: Lunch

12h45 - 15h15: Continuation of country-based working groups

15h15 - 15h45: Nutrition Break (during which rapporteur prepares draft reports from working groups)

15h45 – 16h30: Report to plenary about country-based applied research frameworks

16h30 - 17h00: Closing remarks (A. Zwi/M. Hilson)

Component of post-conflict health sector development	Typical responses	Rationale for typical responses	Research questions
Establishment of policy framework	Most activities seen as 'projects' with limited attention to establishing a policy framework within which projects and activities are located	Lack of data make national planning difficult • Policy frameworks may be too vague to be useful • Wide range of competing interests • Donors do not wish to be constrained by the development of coherent guidelines; they wish to get on with what they are familiar with, often a 'blueprint' from elsewhere, and to do something quickly	• How best can early planning and development of policy proposals take place? • Which are the key areas of capacity which donors should seek to support within the emerging Ministry of Health? • What innovative approaches have been used to make available information and to facilitate communication and debate between key stakeholders?
Donor coordination	Limited coordination - donors agree that coordination should take place but do not wish to be coordinated	• Uncertainty regarding policy direction and legitimacy of emerging state • Wide range of different approaches • Donors identify areas in which they have capacity or comparative advantage	• What innovative approaches have been developed by the Ministry of Health to coordinate and negotiate with donors and NGOs, and to identify key interventions for their support?
Attitudes to working with government	In the presence of contested legitimacy, government is often bypassed; support goes through NGOs and interim UN or other authorities	• Development funding implies working with recognised government counterpart	• What approaches have been taken to overcoming the schism between development and emergency assistance so as to allow for activities directed at longer-term system support ca begin to be conceptualised and implemented earlier on in the period of transition?
Infrastructure development	Attempt to reconstruct whatever previously existed	• Degree of logic in rebuilding what was destroyed • High visibility • Fits in with short-term objectives and timescales of both donors and local policy makers	• What are the most effective tools for undertaking a rapid assessment of the physical and functional capacity of the health care system? • What innovative and effective processes and tools have been used to review needs and distribution of services and to identify opportunities to simultaneously rationalise and mor equitably distribute available services? • What innovative mechanisms and concepts have been used to identify changes in population distribution and to assess their impact on service delivery?
Specific disease problems	Development of vertical programmes with large amount of donor funding and high levels of donor control	• Key problem areas need to be carefully addressed - no time to wait for government capacity to be developed • Well established mechanisms for addressing particular problem e.g. childhood immunization	• What are the positive and negative features of developing vertical programs during the immediate and longer-term periods of post-conflict transition? • What innovative methods have been used to consult and involve relevant stakeholders: including national and local public sector, NGOs, private sector and the international community?
Bringing together conflicting sides	Use of health as a bridge to peace activities; promotion of corridors of tranquility and other methods to cease conflict in order to promote disease control activities	• Recognition of ongoing enmity between groups • Attempt to bring people together to identify and share response to common problems • Health identified as a key activity around which consensus between groups is feasible to achieve	• To what extent is the symbolic nature of health care in restoring inter-community relationships recognised? • In what way have new authorities sought to use health-related concerns to rebuild a sense of community and of trust between communities?
Role of private sector	Assumed to be a desirable partner for providing services; encouragement given to diversifying range of providers and to deregulating the private sector; public sector sometimes inadvertently undermined through lack of support	• Fits in with neoliberal international health sector reform efforts promoted by multilateral and bilateral agencies • Increased choice seen as desirable; • Recognition that private sector emerges and develops during conflict - working with this resource is valuable	• What have been the factors which have most actively stimulated the emergence of the private sector? • How can a weak and emerging authority gain a degree of control over a rampant and unregulated private sector? What are the key initial interventions which can be supported to ensure effective liaison with this sector? • What innovative approaches, tools and processes have been used to assist the state to provide an appropriate policy framework to govern private sector activity and to promote standards and quality of service provision? • How can one use the post-conflict period to develop a more balanced relationship betwee public and private sectors?
Promotion of equity	Considered an important issue which can only be addressed in the longer-term and which can wait until situation is more stable	• Tacit acceptance that relief activities may be inequitable and unsustainable • Inequities in service delivery not identified as important relative to efficiency concerns • Inequities seen as longer-term issue which can be addressed 'later' • Response to inequity seen as part of broad development strategy of government - therefore can wait until government ready, able and willing to tackle this	• To what extent has equity been seen as a key element within the policy framework objectives of post-conflict reform? • What has been the balance between the promotion of equity and efficiency concerns withi the post-conflict policy framework? • What innovative strategies have been established to promote dialogue between competing groups, different areas, men and women, as key elements of post-conflict reform?
Emphasis on training	Often overlooked; when undertaken, usually in-service training with unclear quality objectives; often fragmented and uncoordinated	• Seen as role of government and all services and therefore not requiring specific policies and strategies • When state legitimacy contested, little support to state training systems is provided • Not visible and therefore unattractive to donors • Inadequate attention to organisational and motivational issues	• What innovative but effective approaches have been used to assess human resource needs, to establish human resource capacity, and to develop a realistic human resource strategy? • What are the typical human resource challenges in post-conflict settings? • What policies and strategies have been developed to integrate those trained in separate systems to enhance quality and accountability?
Emphasis on information systems and on data-based decision-making	Information considered a luxury; information not shared; information lost; project based data considered in isolation; big picture often neglected	• Information and decision-making systems opaque and organisation specific • No central repository for information available • Government has little capacity to amass and use available information • Assumption that experience and data from elsewhere will automatically be applicable	• What innovative strategies have been developed to facilitate the availability of documentation, to develop health intelligence, and to establish a central repository for information? • What is the potential to use the new technologies and world-wide web to establish mechanisms for making information more widely available and accessible to all who need i • What innovative incentives (or conditionalities), if any, have national authorities and donor employed to ensure that information is available in the public domain? • What approaches can be developed to facilitate learning from other post-conflict settings and to make data and experience available to others who have and will pass through these transitions?